Treatment Guidelines for Personality Disorders

Third Edition



PROJECT AIR

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Project Air Strategy acknowledges the people of the many traditional countries and language groups within Australia and across the globe. It acknowledges the wisdom of Elders past and present, and pays respect to all First Nations communities of today.



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Preface to the 3rd Edition

Since first being published in 2011, these guidelines have evolved considerably and from the 2015 second edition to this third edition in 2026 a number of important areas of focus have been added, for example lived and living experience including peer work, recovery oriented models of care, cultural responsiveness, lifespan considerations including older persons, creative approaches, virtual therapy modalities, and specific populations including forensic settings and working with parents.

These treatment guidelines continue to be organised according to a typical sequence of a whole of service experience: from a presentation in crisis to a hospital emergency department, through to long-term recovery. It presents practice guidelines in diagnosis, treatment, collaboration and working with specific groups, settings, and models of care.

Section 1 begins with fundamentals for working with people with personality disorder.
Section 2 outlines key principles in assessment, diagnosis and psychoeducation.
Section 3 provides guidance on supporting people experiencing crisis.
Section 4 details individual psychotherapy principles over various durations.
Section 5 outlines other treatment modalities such a group therapy, and
Section 6 considers different groups and settings.

These treatment guidelines have been developed by the Project Air Strategy for Personality Disorders in collaboration with people with lived experience, clinicians, health care managers, researchers and community members as acknowledged in the list of people forming the guidelines development groups across the three editions. They are intended for an Australian and international audience. Project Air Strategy acknowledges the support of the NSW Ministry of Health.

They are written to provide treatment guidance. They offer a framework of care that integrates evidence from science, practice and the lived and living experience of clients and carers. The guidelines are not a treatment manual, training program, academic textbook or systematic review, nor do they offer graded recommendations based on the strength or quality of evidence but cite sources that provide that information to allow the reader to deepen their understanding and to learn more about key points.

The guidelines are focused on the treatment of personality disorders. We acknowledge that research and clinical work have often focused on particular areas such as Borderline Personality Disorder, and that categorical and dimensional developments in diagnosis are evolving. We also acknowledge different brand name therapies but advocate also for common and core factors most associated with symptom reduction, remission and recovery. We acknowledge the multi-disciplinary nature of care and the variety of people across the community who contribute to a person's recovery. Finally, we acknowledge that there is often considerable co-occurring mental and physical health challenges in people with a personality disorder.

Project Air seeks to improve the capacity of mainstream mental health services to manage and treat personality disorder across many points of entry to care, including in an emergency department, inpatient unit, acute and community care service, school counselling and child and youth service, older person's service, juvenile justice and forensic settings and perinatal programs. Project Air Strategy conducts research for discovery, education for inspiration and treatment for recovery, and further information can be found at www.projectairstrategy.org.

A note on terminology

Project Air Strategy have aimed to use generally recognised terms and definitions regarding mental health, lived experience groups and populations. However, we acknowledge that there is often a lack of consensus in relation to preferred terminology and language. Project Air Strategy uses terminology related to people with lived and living experience of mental illness.[1] Each update of the Project Air Strategy Treatment Guidelines will use a specific framework of language. We expect as we continue to learn and hear more diverse opinions from different community members, the language we use in the future will change.

Person / Client

These guidelines use the term 'person' to refer to a person with symptoms of, or a diagnosed personality disorder. The term 'client' is used to refer to an individual who is accessing care or treatment in a health setting.

Carer

Throughout the guidelines, we use the term 'carer' to refer to the client's partner, spouse, parents, family members, cultural elders, mentors, legal guardians, friends or their main support person. It generally refers to people who offer care or support in a non-professional capacity.

There is no one term that accurately captures the full experience of everyone who cares for someone with a personality disorder. Not everyone uses the term 'carer' to describe themselves, nor do some individuals accept the term 'carer' for the people in their life who support them. Some people describe themselves as a 'caregiver', a 'loved one' or any number of other terms.

Recovery

'Recovery' is a personal process of improving quality of life by managing symptoms and living a meaningful life, based on one's own values and goals. Recovery generally refers to the person's longer term mental health journey. This usually extends beyond improving symptoms of mental illness, and may include developing self-awareness, improving relationships, managing emotions, building a stronger sense of identity and hope for the future.

Clinical consultation

The term 'clinical consultation' is used to describe the professional development activity of individual or group supervision and review of practice conducted between clinicians and their peers or professional seniors. This consultation might be profession specific or multidisciplinary. Clinical consultation provides an opportunity for reflection and support, with the goal of improving client care.

Clinician
Clinician is the term used in the treatment guidelines as the overarching term for any health professional, mental health professional, peer worker or therapist.

LGBTIQA+
This acronym is used to refer to lesbian, gay, bisexual, transgender, intersex, queer, asexual and other people with diverse sexualities and gender expression. Project Air Strategy does not intend to be limiting or exclusive of certain groups. We recognise that this acronym or terms are not preferred or used by all people.

First Nations People
This term refers to Indigenous peoples who are the original inhabitants of a country and who maintain connections to their ancestral lands, cultures, and traditions. It recognises peoples who lived in and cared for their lands long before colonisation or the establishment of modern states. In Australia, Aboriginal and Torres Strait Islander peoples are recognised as the First Peoples of the nation.

Virtual Therapy
Virtual psychotherapy is delivered using information and communication technologies, including telephone and videoconferencing platforms. Therapy may be provided entirely through virtual modalities or as part of a hybrid model of care that combines virtual and face-to-face sessions. The choice of delivery mode should be guided by clinical considerations, as well as the preferences and needs of the client and, where appropriate, their carer.

Section 1

Fundamentals

The need for guidance in working with people with personality disorder

A personality disorder is a diagnosed mental illness that can severely impact on a person's quality of life, relationships and daily functioning over time.[1] Individuals can have different types of symptoms, but they usually involve difficulties in affect, identity and relationships (AIR). This may include problems with emotions and impulses that feel either too big and uncontrollable, too blocked and hard to feel, or extremely painful. The person may feel confused about who they are. These challenges can make it hard for the person to understand and relate to others.

A personality disorder is a condition of the brain and mind. It usually has both genetic and environmental precursors. Some people develop personality disorder mostly based on their genetic inheritance, having grown up in supportive families without trauma.[2] However, a portion of the population inherit a genetic predisposition for a temperament that is more sensitive and may be expressed as pronounced interpersonal hypersensitivity.[3] Others develop the disorder without a genetic vulnerability, but the relational environment has been challenging and possibly experienced as neglectful, abusive, unsupportive or traumatic. Many experience a combination of both genetic vulnerability and environmental challenges.[4-6] If someone has a personality disorder, it is not their fault, and they did not cause it.

Symptoms often begin during adolescence when fundamental questions such as "who am I" and "how do I fit in with others" become increasingly important. Difficulties may emerge when a person struggles to understand themself and develop healthy self-esteem. This may contribute to challenges in relationships, which can also exacerbate distress.[7,8] Similarly, fears of being abandoned, or feeling empty inside can be very distressing.[9] Many seek mental health services for support with their symptoms.

The community prevalence for personality disorder is approximately 6.5%-7.8%.[10,11] Considering all mental health presentations to hospital, approximately 20.5% of emergency department and 26.6% of inpatients have a primary diagnosis of personality disorder.[12] Further, an estimated 40-50% of clients engaged with community mental health have a personality disorder.[13] The prevalence of personality disorders is the same in both males and females, with higher severity and prevalence in those under the age of 25.[14] It can be severe, life threatening and associated with self-harm and suicidal risk.[15] It is estimated that more than 10% of people who die by suicide have significant traits of personality disorder and recent contact with mental health services.[16] Lifetime estimates for people with personality disorder include 80% experience suicidal ideas, 50% make an attempt, and approximately 6% die by suicide.[17]

People with personality disorders that seek treatment (e.g., present to emergency departments, require outpatient and inpatient care) are estimated to have health care costs substantially higher than that found for other mental illnesses such as depression and generalised anxiety.[18-20] Lost work productivity due to mental illness, such as personality disorders and substance-related disorders, contributes a loss of AUD$2.7 billion each year.[21] The high societal costs of personality disorders suggest the importance of prioritising the development and implementation of effective early intervention personality disorder treatments.

Personality disorder is treatable. Strong evidence shows that structured psychotherapy is the first line of treatment.[22] Psychotherapy is designed to help the person take active control of their lives by assisting them to understand themselves, reduce the intensity of emotional suffering, and improve relationships with other people. With effective intervention, most people can recover from their symptoms and lead productive and fulfilling lives.

Relationships are at the core of treatment

The following guidelines are based on a relational treatment model proposed by Project Air Strategy.[21] This model advocates an integrative collaborative whole of service approach to the treatment of personality disorders. It focuses not only on the person with personality disorder but also supports carers, health services and clinicians.

Personality disorders have been called “a disorder of relationships” and “the medicine is relationships.”[23] In the relational treatment model, the person’s problems are seen as stemming from problematic and dysfunctional relationship patterns that have developed over time. These relationship patterns are considered both intrapersonal (how the person relates to themself, including their feelings and thoughts) and interpersonal (how they relate to others).[8,24] This relational model assists clinicians to understand their clients’ feelings of unfulfilled relationship needs. It also helps us to understand the persons degree of identity diffusion and self-criticism, where they may be very hard on themselves but also struggle to understand and integrate their emotional experiences.[8]

Health services can acknowledge the core relational challenges facing people with personality disorder by adopting an active, engaged and compassionate approach.[25] The clinician who seeks to approach their work with empathy and compassion, and therefore possesses a level of comfort with the spectrum of interpersonal challenges, can do well offering a helping relationship. Such challenges can include neediness, aggression, hypersensitivity, ambivalence and acts of self-destructiveness. It can also require sitting with emptiness, confusion, and hearing narratives of neglect and trauma. Within this treatment model, clinicians aim to be reflective and thus less reactive to crises. This includes avoiding being over-sympathetic while appropriately defusing aggression to establish safe boundaries.[26] Offering a compassionate approach powerfully helps the client to improve their sense of themselves and their capacity for healthy relationships. The following key principles are recommended.

Key principles for working with people with personality disorders

- Be **compassionate.**
- Demonstrate **empathy.**
- Listen to the person's current experience.
- Validate the person's current emotional state.
- Take the person's experience seriously, noting verbal and non-verbal communications.
- Maintain a **non-judgemental** approach.
- Stay **calm.**
- Remain **respectful.**
- Remain **caring.**
- Engage in **open communication.**
- Be human and be prepared to acknowledge both the serious and funny side of life where appropriate.
- Foster **trust** to allow strong emotions to be freely expressed.
- Be **clear, consistent,** and **reliable.**
- Remember aspects of challenging behaviours have **survival value** given past experiences.
- Convey **encouragement** and **hope** about their capacity for change while validating their current emotional experience.

Adopting these key principles throughout involvement with the person helps to engage them in treatment and fosters a belief that a valuable and beneficial service is on offer. Maintaining such an approach can be challenging and requires considerable skill. Therefore, reflective practice, self-awareness (e.g., knowledge of strong or negative feelings that may be evoked), and clinical consultation are recommended.

Nine core principles of treatment

1. The heart of care is the person

Treatment should be designed to help the person meet their needs, preferences, values and goals.[27] In short, “the treatment should fit the person, rather than the person fit the treatment”. This can also be captured by the phrase “nothing about me, without me”, meaning decisions must be made with the person. This may involve:

- Orienting the treatment to a relational model of care.
- Actively collaborating with the person to develop their Care Plan.
- Valuing their lived experience as an expert perspective on their own needs.
- Allowing flexibility in psychotherapeutic approach, session structure, intervention duration, and treatment pacing.
- Recognising the importance of hope, autonomy, and self-determination in recovery.

2. Prioritise developing a relationship that is safe, trusting, and respectful

Recognise that many people with personality disorder have had experiences of being invalidated, negatively judged for having a mental illness, and may have had their boundaries violated by others. Many have histories of complex trauma. Trauma-informed practice includes:[28]

- Creating a safe, predictable, and non-judgemental environment.
- Provide clear communication about the treatment, including what the service can and cannot offer.
- Prioritising trust-building and consistent therapeutic relationships.
- Empowering the person to have agency, autonomy, choice and control over their care, wherever possible.
- Ensuring a safe space for the person to explore their experiences in a way that respects their preferences and needs.

3. Use language that is respectful, person-first and recovery oriented

Appropriate language is at the heart of communication and is central to establishing self-determination. If harmful or insensitive words are used, feelings of powerlessness can be overwhelming.[29] The words we use reflect our privilege, values, knowledge and any power imbalance that exists across a range of professional and personal contexts. Our language can be improved by:

- Being inclusive, person-first (e.g., say “a person with borderline personality disorder” not “a borderline” or “a PD”), affirming, clear, trauma-informed, and amplify choice and agency.
- Conveying hope and respect for the person and validate their challenges (“I can see this is hard for you”, “people can recover and help is available”, “you are not alone and many people recover from this disorder”).
- Use strength based and compassionate phrases (e.g., “I can see you are trying hard to get your needs met”).
- Use simple and clear communication. Avoid using jargon and other medical terms that can disempower a person.
- Be respectful of diversity and ask about preferences. For instance, ask how a person prefers to be addressed and check pronouns or titles.
- Talk about suicide respectfully (e.g., “died by suicide” rather than stigmatising phrases such as “committed suicide”).

4. Include carers

Families, partners, and close friends can be important supports in recovery. However, they may feel excluded from engaging with health services and report significant burden and stress in their supportive role.[30, 31] Where appropriate, and with the person’s consent:

- Provide carers with psychoeducation about personality disorder.
- Involve carers in goal setting, care planning and discharge discussions.
- Offer carers access to their own support services to prevent burnout.
- Maintain confidentiality, while acknowledging the unique needs of the person and their support network.

5. Diagnosis is an important human right

People should be informed in a timely and accurate way about their condition and treatment options. Many people with personality disorder report that getting an accurate diagnosis delivered in a compassionate way was an important and validating moment in their recovery.[32] It is a fundamental human right to be told accurate information about your health. However, many report histories of not being given timely information about their diagnosis, or having health practitioners actively suppress giving the diagnosis. This may result in long histories of misdiagnosis, inappropriate treatment or having care denied. This in turn perpetuates stigma and poor outcomes. Diagnosis is best made by a clinician who knows the individual, and has taken a thorough history of mental health symptoms, in a non-emergency setting.

6. Treat the disorder equally in both males and females

Although the prevalence of personality disorder is the same in males and females, there is evidence that men are often overlooked in health care decisions and can miss out on treatment due to bias and misinformation.[33] This can result in men being left untreated and having worse long term outcomes or even premature death. This bias, particularly in Borderline Personality Disorder (BPD), has permeated the scientific literature (e.g., studying women only), how people are transitioned (e.g., men being referred to substance dependence programs despite a primary personality disorder diagnosis), or how services are delivered (e.g., women only group therapies). These can reinforce social biases and gender stereotypes around asking for and receiving emotional support.[33] Such biases can translate into women being overlooked or misdiagnosed when the personality disorder characteristics (e.g. antisocial behaviour) are more commonly associated with masculinity.[34]

7. Recognise the disorder in vulnerable groups

Personality disorder treatment is important for all diagnosed people. Research suggests that some groups are more vulnerable to personality disorder. These include people questioning their sexual identity, LGBTIQA+ persons, people from culturally diverse backgrounds, people with non-English speaking backgrounds, migrants especially those forced to leave their home country due to war or trauma, and people of Aboriginal and Torres Strait Islander background.[35] In addition, people with co-occurring disorders may be more vulnerable due to the complexity of their condition, for example people with physical health conditions, complex trauma or post-traumatic stress disorder (PTSD), substance dependence, eating disorders, neurodiverse conditions, and other challenges. In general, it is important to treat the whole person and develop plans for all their concerns, including exploring any processes or beliefs that may inform their experience of symptoms.

8. Review treatment goals regularly together

Treatment needs can change as the person's symptoms, strengths and goals evolve. Good practice includes:

- Setting clear, measurable, realistic and mutually agreed goals at the outset of an inpatient admission or community episode of care.
- Involving the multidisciplinary team in goal reviews to ensure recommendations are wholistic and realistic.
- Reviewing goals at predetermined, regular intervals.
- Using structured processes, such as ward rounds, community care consultations, joint meetings between providers and other methods of communication to inform decisions about treatment adjustments, and how to best manage transitions.

9. Adopt a whole of service approach

The relational model emphasises that treatment should be integrative and collaborative. Project Air Strategy has developed a whole of service approach. This has also been extended to early intervention, working in schools and with child and youth services.[36-38] Here are some key principles:

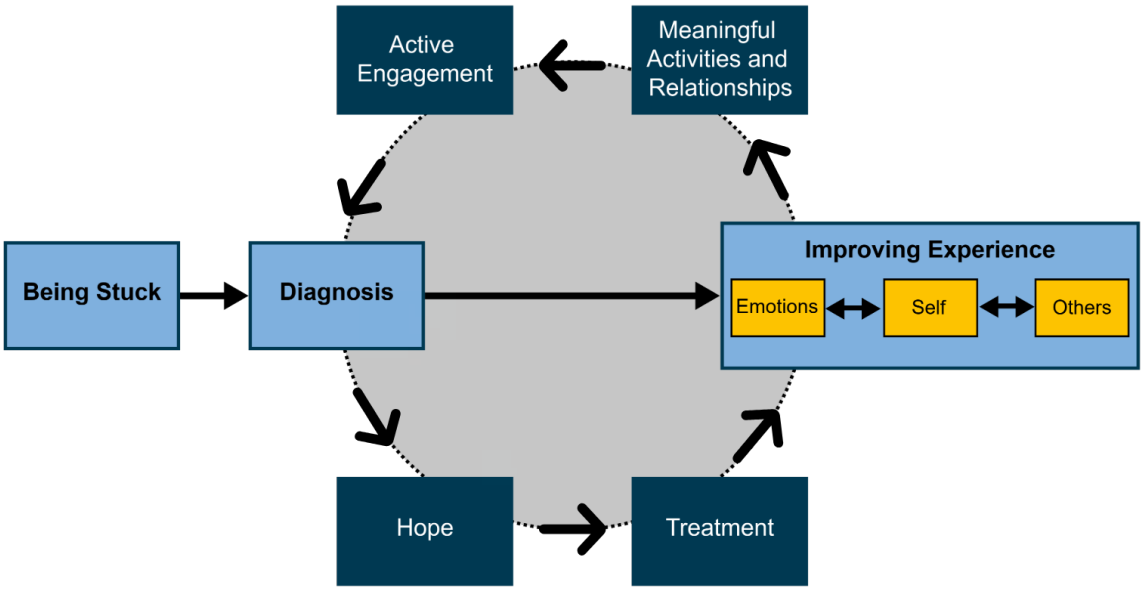
- Treatment of people with personality disorders works when it is collaborative, based in multi-disciplinary teams, and is well integrated between individual clinicians and services (such as public services, private, non-government, general medical practitioners and physician services, mental health, drug and alcohol, human and community services, justice, housing, and police).
- A primary clinician should be identified who acts as the conduit for collaboration and coordinating care. This is usually the person who has the closest and most ongoing relationship with the client, so may change as treatments change. Handover of this role between practitioners is important so the client feels ‘held’ and ‘connected’ by services.
- It is important that a common shared treatment model is understood by the person with personality disorder, clinicians, carers and all others involved in the person’s treatment.
- Policies around admission to hospital and referral pathways need to be clear and consistent, with assertive follow-up and defined treatment teams trained in appropriately responding to and managing complex risk.
- If medication is being considered for a person’s co-occurring diagnoses or symptoms, accessible and clear information must be provided, with an opportunity to ask any questions from the person and their carers.
- Support and clinical consultation for and with clinicians is an important and integral part of evidence-based treatment for personality disorders.
- Clinicians should be offered training in the treatment of people with personality disorder and have the support of a team, so they are not isolated.
- Treatment works best when people with personality disorders are actively involved in the development of their Care Plan, based on their identified needs and goals.
- A personality disorders-inclusive health service gives hope to people with personality disorders, their carers and clinicians about the efficacy of treatment.

Use a recovery focus

People can and do recover from personality disorder.[22, 39-42] The diagnosis of personality disorder can be considered one of the most hopeful of the mental health conditions, despite its severity when untreated, because most people can recover and stay recovered with effective intervention. The treatment of personality disorder involves a process of personal recovery. Through finding safe people and spaces, a person can develop self-acceptance and a healthy self-identity. This offers them autonomy to make wiser choices for their current life and future. This process develops their strengths and fosters relational connections to others.

Project Air Strategy advocates for listening to the lived experience stories and accounts of people who have recovered to discover the pathways to recovery and what health services and clinicians can learn about that journey.[43] People with lived experience highlight these key considerations:[43, 44] 1) the importance of obtaining and sustaining therapy and the therapeutic relationship; 2) keeping up some hope to keep going and being thankful for improvements; 3) validating the realisation of how our past can affect us; 4) achieving more acceptance of emotions and the self; 5) daily work is needed to practice and persist with these recovery strategies.

Stages and processes of recovery in personality disorder



Project Air Strategy's work on understanding the recovery journey discovered many routes, but there were four main processes 1) active engagement, 2) hope, 3) treatment and 4) meaningful activities and relationships (see Figure).[43] Early recovery involves overcoming: 1) being stuck, 2) getting a diagnosis, and 3) attending to here and now experiences to understand emotions, develop self-identity, and improve relationships including trying to understand the perspectives of others.

The absence of accurate and helpful diagnostic information leads many people to be stuck for an extended period. Diagnosis is often considered a significant turning point, helping to focus on the importance of seeking psychological therapy.[32, 43] Psychotherapy sets the stage for a broader focus on cultivating agency, finding personally meaningful goals and activities in the person's life. However, the person needs to find some stability (housing, financial, relational) to undertake this work.[44] Seeking stability thus is the first important goal on the recovery and psychotherapeutic journey, because a person in crisis with no stability will struggle to make progress. Only then can there be an exploration of vocational goals and relationship enhancement that are central to effective recovery.

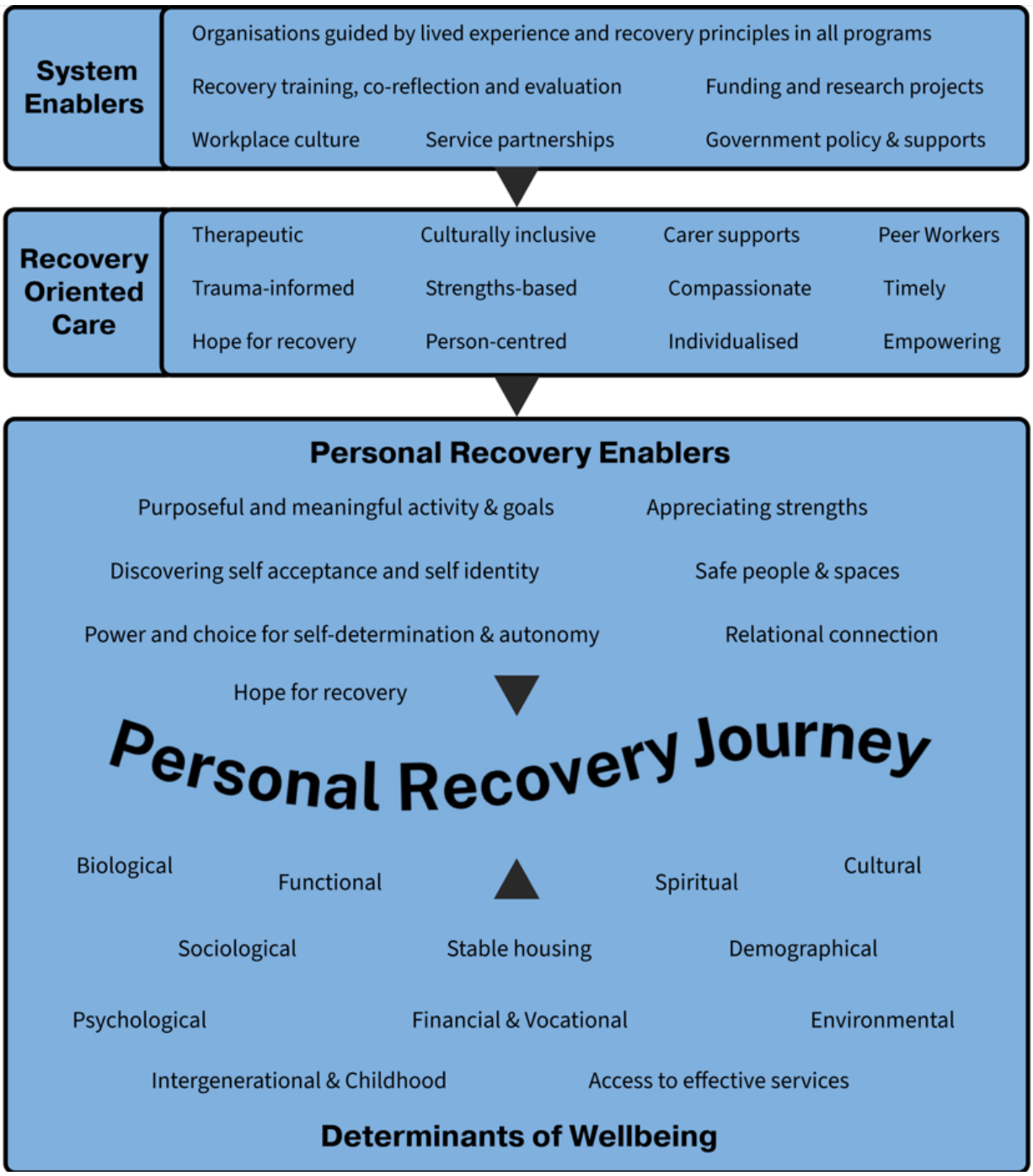
Major domains of recovery for people with personality disorders



Psychotherapy thus needs to hold in mind the importance of stability and relational safety as an initial first goal. Once these have been achieved, the environment of therapy can then support individuals to feel safe to express themselves, to take steps forward and to experience less shame and increased self-acceptance. Wholistic approaches will thus resonate with individuals more than having a sole focus on specific behavioural changes.

A recovery journey is thus very dependent on a multitude of factors, as seen in the following figure.

Some enablers of personal recovery



Take a whole person approach

A whole person approach to care may focus on all aspects of health that personally matter to an individual from a physical, cultural, religious, social, political and familial perspective.[45, 46] When working from a curious stance informed by a whole person approach, there can be greater opportunity to understand the varied wellbeing priorities of the individual, further strengthening a good therapeutic alliance.[45, 46] Maintaining focus on the whole person can also guide clinicians with a deeper awareness of other health domains that may require further treatment. Improving wholistic care requires the commitment of health care systems and individual clinicians.

Personality disorder and physical health concerns

When working with individuals with personality disorder and complex mental illness it is also important to consider their overall health.[47] We know from studies that living with co-existing mental and physical illness may be a risk for premature death, often from preventable physical health conditions.[48, 49] Diagnostic overshadowing, which occurs when a physical health complaint or manifestation is mistakenly attributed to a mental illness, is a form of recognised discrimination.[50]

Therapeutic priority may involve treatment of co-existing conditions for effective outcomes.[49] Below is a summary of some known links between personality disorder and co-occurring physical health conditions.

- People with personality disorder are disproportionately affected by a range of physical health issues, including chronic pain, chronic illnesses, sleep disturbances, and obesity.[51]
- There are established associations between personality disorder and an increased risk of gastro-oesophageal reflux disease, syncope and seizures, and recurrent headaches.[51]
- Cardiovascular disease, and cancer have been found to be main contributors for early mortality for individuals living with personality disorders, which have known lifestyle concomitants such as tobacco smoking.[52]
- Dysregulated physical pain is common in BPD and plays a significant role in shaping health outcomes, including heightened symptom severity, increased vulnerability to chronic pain conditions, and elevated risk for substance use. Clinicians may consider how chronic pain and illness may elevate emotional dysregulation and vice versa in people with personality disorder.[53]

Lifestyle interventions are core components of mental health care for personality disorder. Physical activity,[54, 55] mindfulness,[56] and sleep[55, 57] show the strongest evidence for improved symptoms, while diet[55] and green space[58] are emerging areas. Key considerations for effective implementation include personalisation to individual and environmental factors, facilitation by qualified staff, flexible delivery (e.g., face to face or virtual modalities), inclusion of lived experience, attention to socioeconomic context, and ongoing evaluation for program longevity.

Ensure care is culturally responsive and safe

Personality disorders involve challenges in affect, identity and relationships. How these are expressed and interpreted depends on the socio-cultural, political and familial history, and the person's current social-linguistic and cultural context.[59] How an individual's culture informs their sense of identity, beliefs about mental health and emotional wellbeing, approaches to help-seeking, comfort within the dominant cultural community (such as western or colonised systems), spirituality, and roles within communities (such as mob in Indigenous communities), family, and community are all foundational considerations in building culturally responsive practice. Culturally responsive care involves building respectful, flexible, and informed relationships that honour the person's unique cultural identity while supporting their recovery journey. It is a way of being with others and actively listening, by honouring a persons' identity, acknowledging history, and working collaboratively to create healing environments where every person can experience dignity, safety, and belonging.

Clinicians have a responsibility to ensure assessment, educational resources, services, and communication are culturally and linguistically responsive. Wherever possible and appropriate, offer flexibility in service delivery (e.g., alternative settings, family-inclusive sessions). Many individuals from culturally diverse backgrounds may have trauma histories (e.g., migration, forced displacement, racism). The relational model guides clinicians to ensure all aspects of a person's care are sensitive to their individual needs. This includes consideration of potential trauma, especially with people from refugee or war-affected backgrounds, survivors of stolen generations and forced removal, experiences of out of home care, and recognising critical experiences of displacement, colonisation, grief and loss.[60]

Cultural differences in personality disorders

There are some cultural differences in the diagnosis, prevalence and symptoms of personality disorder. Studies in China, India and Japan highlight that some forms of self-harm (e.g., self-poisoning or overdose) are more common compared to other forms of self-harm (e.g., cutting) in western cultural groups.[61-64] One possible explanation is that people from Eastern Asian cultures are more likely to suppress and internalise emotions. Impulsive behaviours, including self-harm, are highly stigmatised and therefore may be kept more private. In some cultures, where extended families live in close proximity, emotional and interpersonal challenges are so intertwined they are seen as a single issue, whereas others internalise these problems as somatic concerns with higher pain experiences. There are also challenges in the expression of mental health problems by males in some social and cultural contexts. This may be associated with greater loneliness and problematic relationships.[60] Contextualising socio-cultural issues in treatment is important to understand how personality vulnerabilities may have developed and are currently expressed and responded to.

Key considerations to facilitate culturally responsible care

In providing culturally responsive care, clinicians may explore the person's cultural background, faith, language, migration story where relevant, and support networks as part of every assessment. This allows the clinician to understand the expression and meaning of personality disorder symptoms in relation to the person's cultural context.

Cultural awareness and humility require the clinician to:

- Acknowledge their own cultural background, biases, and limitations.
- Approach clients with curiosity and openness, avoiding assumptions.
- Practice cultural humility, which is a lifelong commitment to self-reflection and learning from others.

Understanding the impact of culture on personality and distress requires the clinician to:

- Recognise that cultural norms shape how personality traits, and how the experience of an individual 'self', may be expressed and interpreted.
- Be cautious about pathologising behaviours that may be culturally normative.
- Consider cultural views on identity, emotional expression, relationships, and help-seeking.
- Create an environment where individuals feel respected, heard, validated and understood.
- Empower clients by validating their cultural identity and experiences.
- Be sensitive to the impact of colonisation, racism, intergenerational trauma, and systemic disadvantage.

The following are key ways to support culturally responsive care:

- Use interpreters when language barriers risk communication errors.
- Use cultural consultants and refer clients to these consultants where possible.
- Ensure assessment tools are culturally appropriate and validated for the population.
- Interpret symptoms within their cultural context (e.g., avoid rigid application of diagnostic criteria developed by dominant cultures and groups).
- Consider culturally appropriate expressions of distress and alternative understandings of mental health and illness.
- Work collaboratively with the person's family or community where appropriate.
- Understand family roles, community structures, and cultural healing practices.
- Build trust over time, particularly with communities that may have a history of mistrust in services.

Sustaining a focus on cultural safety can be done by:

- Engaging in regular training on cultural responsiveness, including Aboriginal and Torres Strait Islander or First Nations people's mental health.
- Using clinical consultation to reflect on cultural dynamics and countertransference in cross-cultural work.
- Providing ongoing training in cultural competence, cross-cultural communication, and bias awareness for all staff.
- Encouraging reflective supervision to explore clinicians' own cultural assumptions and power dynamics.
- Promoting workforce diversity and inclusion, ensuring clinician and leadership roles reflect the multicultural communities serviced where possible.

Specific considerations for working with Aboriginal and Torres Strait Islander or First Nation's people

The oldest living cultures in the world have core knowledge to share with non-Indigenous societies about survival, sustainability, wellness and health. Colonisation is recognised as having an ongoing, devastating impact on the disadvantage and poor health of First Nations peoples worldwide, through social and political systems that maintain disparities.[65-67] In Australia, the historical and ongoing effects of colonisation and racism contribute to current inequities in the health and wellbeing of First Nations people.[66-68]

Cultural safety is determined by First Nations individuals, families and communities. In Australia, Aboriginal and Torres Strait Islanders require access to culturally safe and respectful healthcare that is sensitive to the impacts of colonialisation, forced displacement and trauma. First Nations peoples from anywhere in the world may have similar and specific issues that need to be considered. Culturally safe practice is the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive health care free of racism.[69] Care may be provided within a rights-based approach to health care supported by the United Nations Declaration on the Rights of Indigenous Peoples together with the ongoing commitment to learning, education and training from health services and clinicians.[70]

To ensure culturally safe and respectful practice for First Nations people, health practitioners must:

- Acknowledge colonisation and systemic racism, social, cultural, behavioural and economic factors which impact individual and community health.
- Acknowledge and address individual racism, their own biases, assumptions, stereotypes and prejudices and provide care that is wholistic, free of bias and racism.
- Recognise the importance of self-determined decision-making, partnership and collaboration in health care which is driven by the individual, family and community.
- Foster a safe working environment through leadership to support the rights and dignity of Aboriginal and Torres Strait Islander people and colleagues.[69]

In Australia, it is critical to recognise that Aboriginal and Torres Strait Islander concepts of health are wholistic, encompassing physical, emotional, social, spiritual, and cultural wellbeing of both individuals and communities.[71, 72] Cultural factors such as connection to Country and caring for Country, connection to community, connection to mob (family), knowledge and beliefs, language, self-determination, family and kinship, and cultural expression are protective and positively influence First Nations people's health and wellbeing.[65, 73]

A key theme in the discussion regarding how to achieve significant and sustainable change in the health care of Aboriginal and Torres Strait Islander people is the need for decolonisation.[74, 75] To effectively work with people affected by historical trauma, health care professionals should be informed about the history and ongoing impact of colonisation. This can be considered in the health care approach, such as maintaining a focus beyond skill-building and towards a wholistic understanding. This includes sensitivity of the ethnocentric assumptions and race-based stereotypes influencing current-day deficit discourse that do not consider the socio-economic disadvantage in which individuals and communities are embedded. The deficit discourse has real-world outcomes for identity formation, educational attainment, health and wellbeing, contributing to forms of external and internalised racism.[76]

Strengths-based approaches seek to move away from the traditional problem-based paradigm and offer a different language for thinking about and discussing ideas. This may include asset-based approaches, resilience, cultural appropriateness, social determinants of health and ecological theories, protective factors, empowerment, wholistic approaches, wellness and wellbeing, strengths-based counselling approaches, positive psychology, and decolonisation methodology.[76] However, strengths-based approaches continue to require ongoing consideration of the wider context of power and inequality.

Indigenous social and emotional wellbeing is a multidimensional concept offering a collectivist perspective that acknowledges Indigenous Australian worldviews and expressions of culture. It encompasses connections to land and Country, culture, spirituality, ancestry, spiritual dimensions of existence, family, and community, body, emotions and mind,[77] and the complex influence of wider historical, social and political determinants.[71, 78]

Connection to Country

Country is an area or place where people have a traditional or spiritual association.[78, 79] Several studies have shown a link between feeling 'connected to Country' and a positive sense of wellbeing among Aboriginal and Torres Strait Islander individuals and communities in diverse geographic contexts all around Australia.[79-82] As health professionals, it is important to ask about an individual's connection to country and to continue to learn about and acknowledge the enduring impacts of colonisation, dispossession, systemic racism, and intergenerational trauma on social and emotional wellbeing.

Self-determination

Self-determination is an ongoing process of ensuring that people can make decisions about matters that affect their lives through choice, participation and control. It is important to embed cultural safety and self-determination as foundations of care to ensure that all clients, especially those from minority cultural groups, have control over decisions affecting their lives, health care and communities.[83] Individuals have a right to freely determine their political status and economic, social and cultural development.

Clinical yarning

Yarning is a conversation that involves the sharing of one's own stories and the creation of new knowledge. It prioritises Aboriginal and Torres Strait Islander ways of communicating, in that it is culturally appropriate and respectful. Yarning involves a 2-way dialogue of sharing and receiving information. It is built on the relationship that the parties involved have with each other, following certain cultural protocols and respects what each person wishes to get out of the dialogue.[84]

Yarning in a clinical setting has three interrelated areas that are recommended to engage a person in their health care journey:

1. The first involves the 'social yarn' where the clinician tries to find common ground with the person. This first part of the yarn is the stepping stone for applying the other two areas of the clinical yarn.
2. The second dimension is the 'diagnostic yarn' where the clinician encourages the person to tell their health story. This means the person might describe the events about their life that may relate to their present symptoms. This is best performed as an open-ended dialogue where the clinician will unpack the relevant pieces of information and apply it to their own knowledge. It is critical that this information is co-managed and any consideration of diagnosis is led with compassion.
3. The third part is the 'management yarn'. A clinician may ask, "How can I help you with this?", and "How are you already coping and what are your inherent strengths?" In this stage, the clinician will provide clear information to the person. Clinicians may use metaphors and stories connected to the person's life to make it easier for them to understand the condition they have.[84]

Assessment considerations

Research into Aboriginal and Torres Strait Islander people's mental health is limited by the continued failure to use culturally valid, psychometrically sound, and clinically valid screening tools. Some measures that may be appropriate include: The Strong Souls Assessment[85] - a culturally informed tool designed to assess social and emotional wellbeing (SEWB), that supports culturally responsive practice; Australian Aboriginal Version of the Harvard Trauma Questionnaire (AAVHTQ);[86] Growth and Empowerment Measure (GEM);[87] Indigenous Risk Impact Screen (IRIS);[88] and the Modified Kessler Scale (MK-K5).[89]

Aboriginal and Torres Strait Islander people in Australia have suicide rates that are at least twice that of non-Indigenous Australians.[90] When assessing risk, it is also important to consider measures of resilience, where social, emotional, spiritual, and cultural wellbeing of the whole community is seen as central to the health of each individual.[91] Risk amplification is the complex interaction of factors including histories of trauma or grief from discrimination, removal of children, premature deaths of community members and their impact on cultural identity, sexual or physical abuse or neglect, physical and mental illness, interpersonal violence, history of self-harm, substance abuse, juvenile detention or police custody.[92] When completing a Care Plan with Aboriginal and Torres Strait Islander people, consider using the Menzies Institute 'Stay Strong Plan'.[93] Alternatively, some people may prefer the Project Air Strategy Care Plan that is personalised to their individual circumstances.

Include carers

Including carers not only helps the person with personality disorder, as carers are often their main source of support, but can also help to improve relationships. Mental ill health does not occur in isolation, nor does it only impact the individual experiencing it. Every situation involves a network of people, each with their own perspective and understanding of what's happening. It is important where possible for service providers to actively acknowledge and include carers by listening to their insights, respecting their needs, providing appropriate referrals, and working collaboratively with both consumers and carers as partners in care. This approach leads to improved family environments, reduces stress and anxiety for carers, enhances the capacity and willingness of families to remain involved, and increases staff satisfaction.[94]

Consider these important points for practice:

- Document all carer contacts, consents, and plans clearly in the case notes.
- Demonstrate empathy and care for the carer and family members.
- Clarify roles to promote the understanding that managing symptoms and implementing change is the focus of treatment with a qualified mental health clinician and not the responsibility of the carer.
- Involve carer peer workers where available, as they offer empathy, specialist knowledge and lived experience.[95]

Carers may expect:

- Recognition of their caring role.
- Sharing of information regarding diagnosis, treatment and plans for discharge.
- Opportunities to ask questions, provide feedback, and discuss concerns.
- Support in their caring role and in negotiating the mental health service system.
- Consideration and responsiveness of culturally and linguistically diverse communities.

The following areas of support might be considered:

1. At the initial assessment and engagement with the client

- Identify who the carers are and their role (e.g., parent, partner, sibling).
- Ask the person with personality disorder if they consent to involve their carer. Obtain written consent.
- If the person is unwilling or reluctant to involve their carer explore the reasons in an open and non-judgemental way. Consider offering limited consent options (such as agreeing on what information can and cannot be shared).
- Ask the person if they have any observations or perceptions of how their carers are coping emotionally, what support they have, and what they might need.
- Offer to set up a separate carer/family meeting and ask whether the person would like to be present or not.

2. Provide carers with psychoeducation about diagnosis and treatment

- Where possible with the client's consent, set up a meeting with carers either face to face or by virtual modalities.
- Explain what a personality disorder is using accessible language, provide fact sheets and links to reputable websites.
- Discuss potential causes using the biopsychosocial model[96] to explain the relationship between genetic vulnerability and environmental stressors and how these can be modified through treatment. Offer a compassionate approach, being mindful that carers may feel judged or blamed.
- Discuss stigma and common misconceptions about the disorder, providing a hopeful message that treatments generally work and people can recover.
- Discuss current treatment plans and options for future care that are available, how they work, and what outcomes to expect.
- Provide information about the mental health system and other relevant resources.
- Allow the opportunity for carers to ask questions.

3. Suggest ways carers can be involved in supporting treatment

- Involve carers in treatment planning where possible.
- Share Care Plans with carers.
- Discuss what the carer can do in a crisis (e.g., suicidality or self-harm episodes).
- Offer a point of contact for carers when needed (e.g., family worker or clinician).
- Consider collaboratively completing a Carer Plan (see the Project Air Strategy website; https://www.projectairstrategy.org).
- Reinforce the importance of the client obtaining and sustaining involvement in evidence based treatment as the primary goal to recover from the disorder.

4. Provide carers with education about helpful relationship skills

- Help the carer to clarify boundaries and limits of their role, and how to set these in a way that respects the autonomy of both parties.
- Reinforce the importance of self-care, including not neglecting the carer's own mental and physical health.
- Consider how the nature of the caregiving relationship may raise specific concerns for both the carer and the person with personality disorder (e.g., parents, spouse/partner, sibling).
- Discuss ways to compassionately respond to emotions without judgment.
- Consider helpful ways the carer can manage their own distress.
- Provide information about carer support groups and organisations that can provide structured programs for carers.
- Emphasise that support groups can help develop connections with others, problem solve difficult situations, reduce stigma, burden and isolation.
- Be willing to provide referrals for carers own needs.
- Where relevant, set up a review appointment.

A Carer Plan is a useful way to structure consultations with carers. The plan helps the carer: 1) clarify their carer role and goals as a carer, 2) specify helpful strategies when the person they care for is struggling and in crisis, and 3) emphasises the importance of the carer having their own support for their role. See the Project Air Strategy website (https://www.projectairstrategy.org) for additional resources for family members and carers.

Carer Plan

Name: **Clinician Name:**

My main goals and problems I am working on in relation to my carer role

(1) In the short term

(2) In the long term

My carer crisis survival strategies

Warning signs that the person I support is unsafe, in distress or crisis

Things I can do when the person I support is unsafe, distressed or in crisis that won't harm them or me

Things I have tried before that did not work or made the situation worse

What I can do to take care of myself in stressful times

Places and people I can contact in a crisis:

Lifeline: 13 11 14 **Emergency: 000** **Local Service:**

My support people (e.g. *friends, family members, partner, psychologist, psychiatrist, social worker, GP*)

Name	Contact Details	Role for me	OK to Contact?

Signature: **Clinician's Signature:**

Date: **Date of next review:**

Copy for the: Carer / Clinician / Other (please specify)

www.projectairstrategy.org

Reluctance to involve carers and family members

When carers are offered information, skills and support the family environment improves, thus providing the person with personality disorder more stable and compassionate supportive relationships.[97] However, sometimes people with personality disorder may be reluctant to involve others in their care. This may be due to several factors including problems in relationships, feeling alienated from family members, feeling guilty about involving carers, fearing the clinician will judge their family or carer relationships, or issues related to abuse or neglect.

It is important to acknowledge that the person with personality disorder has a right to decide the level of involvement of their carer. It is useful to explore the reasons for the person's reluctance or resistance. This will assist in developing a Care Plan, case formulation and treatment plan. General anxieties and fears about involving families can usually be overcome by explaining the benefits of inclusion. It may be possible to discuss options of limited consent with the person. This may include agreement on what information can and cannot be shared, or whether the person would prefer to be present in all carer discussions. Decisions about consent may change. If the person does not consent to carer involvement, it may be beneficial to revisit this decision later. Depending on the local laws, carers may remain entitled to a basic level of information. This may include admissions, discharges, transfers and tribunal hearings and general information about mental health.

What if a family member is a perpetrator or the family is considered too problematic?

People with personality disorder may have experienced early trauma including childhood neglect or abuse, or be experiencing current domestic violence. The perpetrator of abuse may reside in the family or have a significant relationship with the person with personality disorder. A thorough assessment of the family relationships will assist in developing a treatment and support plan. If the person continues to be at risk, refer to your health service safety and risk policies and procedures. You may need to take action to support safety and promote justice.

There may be times when a family member is considered problematic (e.g., the carer has severe alcohol or substance dependence) and services may consider excluding the family member's involvement in the person's care. However, if the carer is excluded from the service, it may jeopardise the person's engagement in treatment, especially if the person is dependent on the carer (e.g., reliant on the family for housing, financial support or transport). These situations are complex, sensitive, and often require clinical consultation with senior colleagues to establish clear treatment goals and boundaries.

Ensure clinicians are supported

Providing treatment for people with personality disorders can be challenging for even the most experienced clinicians.[26] Without support, some staff might develop negative attitudes and biases towards treating people with personality disorders, especially when the clients they work with are at the early stage of their recovery journey. Given these challenges, it is important that clinicians are supported to work effectively. It is well established that clinical consultation supports clinicians to provide effective treatment for people with personality disorders.[25]

Clinical consultation is built into evidence based psychotherapy for people with personality disorder. A primary goal of clinical consultation is to increase the clinician's ability to respond thoughtfully, rather than reactively. Reflective approaches to consultation support clinicians to develop self-awareness. Consultation can also help clinicians develop realistic expectations of treatment based on empirical evidence and understanding the long term recovery journey.[98-100] Regular clinical consultation is recommended. It can help at times if the clinical consultation is external to the service, as it may help the clinician view the clinical situation with greater clarity.

Clinical consultation can:

- Provide effective containment for the clinician. The clinical consultant can function as a historian of the clinical process and act as an anchor when the clinician is caught off guard.
- Provide a model for shared responsibility, including the clinician, treating team, manager and clinical director. Clinical consultants do have some responsibility for the guidance they provide and for the foreseeable actions of the staff receiving guidance from them.
- Help share the risk so that significant decisions are not just based upon one clinician's decision-making process.

Conflicts within treating teams

Treating teams may find they experience disagreements about the treatment of an individual with personality disorder. This may be the team's reaction to the person's behaviour and not necessarily something the person is doing to the team. Different staff member's experiences of the person may lead to differences in opinion among a team struggling to understand their primary issues. Team disagreements may also reflect the person's fragile sense of self, their own internal chaos, and ongoing problems in sustaining relationships.

Treatment of personality disorder is most effective when members of treating teams learn to manage their reactions, communicate with each other and develop a shared approach.[101] Group clinical consultation and peer consultation are recommended for all team members to assist with this.

Team leaders and managers

Team leaders can play an important role in modelling adaptive and constructive responses to people with personality disorder. Support from management is also vital in acknowledging that clinical consultation is a legitimate part of the clinician's role and does not signify weakness or ineffectiveness. Managers may also support clinicians in the treatment of people with personality disorder by ensuring access to required training and resources.

Understanding common clinician reactions

A clinician's personal reactions toward the person they are treating may be influential in the treatment process.[102] These personal reactions can provide:

- A helpful process that allows the clinician to better understand the way the person may influence others. Through noticing the way the person affects the clinician, the clinician can see how the person affects other people in their life.
- A challenge for the clinician when they experience negative emotions toward the person, or pessimism about the likelihood of a positive therapeutic outcome. This can result from issues in the clinician's own life or from aspects of the person's presentation.

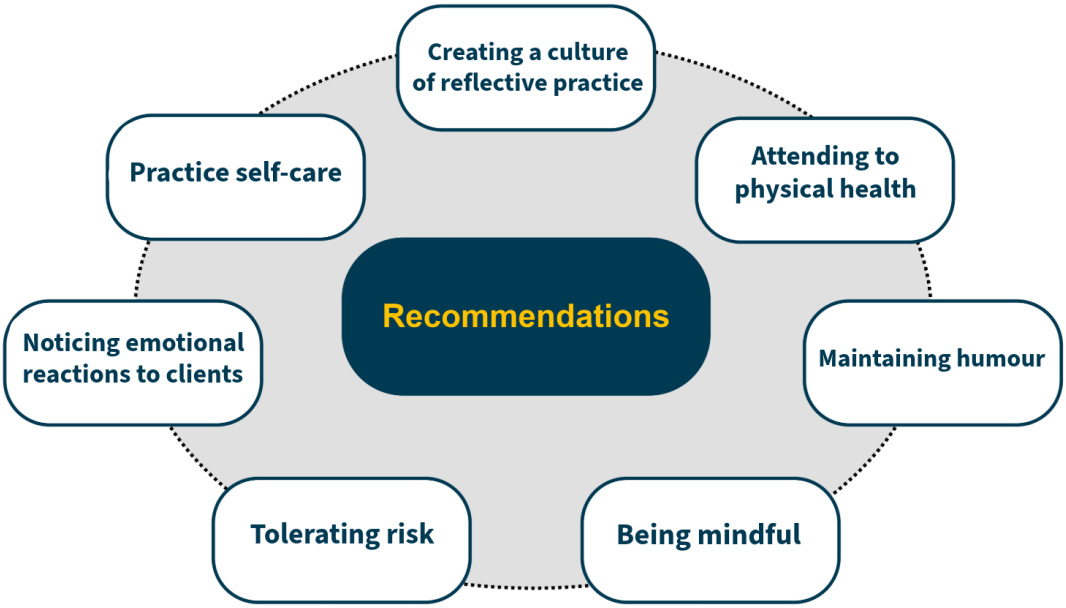
Clinical consultation provides a context for examining these issues (sometimes referred to as 'countertransference').[26, 102] It can facilitate insight into personal reactions and develop skills to enable these to be understood.

One way of enhancing the clinician's capacity for thoughtful intervention is to identify the function of the feelings the clinician is having. For example, the clinician may feel guilty about not being able to solve their client's problems and may do more for their client to compensate for these feelings. Many clinicians, particularly those early in their career, are reluctant to share intense feelings in clinical consultation. To help overcome this, the optimal approach is to steer a middle course between analyses of the clinician's reactions toward the person they are treating with an educative focus on aspects of treatment.

Ensure clinician self-care

The treatment of personality disorders, whilst rewarding, can also be emotionally challenging for treatment providers. Thus, it is important to encourage clinicians to engage in their own self-care. This could include addressing physical, emotional, spiritual, intellectual, social, relational and safety needs.[103] Students and early career mental health professionals may be encouraged to adopt self-care routines early, so that they establish self-care habits that support their professional longevity. Having an awareness of the risks of vicarious trauma, burnout and secondary stress equips health care workers to respond proactively to periods of stress and prioritise self-care as a part of ethical practice.

Some aspects of self-care for clinicians treating personality disorder



Clinicians face a range of occupational hazards, including stress, vicarious trauma, burnout and compassion fatigue when working with clients who have complex mental health needs.[104] The additional requirement of managing confidential, non-reciprocal relationships and bearing high ethical responsibilities add further to the load mental health workers carry. Early career professionals are more vulnerable to work related stress than more experienced mental health workers.[105] In addition, many clinicians who work with highly complex suicidal clients have a range of negative cognitive and emotional reactions (countertransference) which can include distress, concern, hopelessness and inadequacy.[106] These emotional reactions can heighten the work-related stress clinicians experience.

The vulnerability of clinicians to burnout, vicarious trauma and emotional distress underscore the importance of self-care, which has been found to be associated with lower stress levels and greater life satisfaction and self-compassion in health professionals.[107] Improved self-care amongst mental health professionals is also important for client safety. Recent research has found that clinicians who have a high case load coupled with low satisfaction in their personal life are more likely to violate professional boundaries.[108] Therefore, self-care and a healthy work life balance are beneficial for mental health professionals and important for client safety.

Organisations can contribute by creating a culture of self-care to reduce potential stigma, shame or embarrassment staff may feel about seeking assistance. This can be achieved by providing interventions focused on self-care, encouraging staff to take up employer provided counselling services, promoting physical health and creating environments and social activities that promote positive relationships between staff.[109]

Clinician self-care is especially important if there are sentinel events in the workplace, such as when a client dies by suicide. These events can induce helplessness, sadness, shock, grief, guilt and anger. Speaking with trusted senior colleagues, mentors and peers is usually very helpful. During this time, it can help to engage in self-reflection with a colleague, allowing time to review the issues and prior history, as well as setting aside time to acknowledge the impacts. Clinical consultation is critical at these times.

Self-care involves not only attention to mental health, but also healthy lifestyle habits, such as maintaining good nutrition, engaging in regular exercise, seeking out social support and getting adequate sleep. Regular physical exercise is associated with greater resilience to stress[110] and lower rates of burnout.[104] Furthermore, there is growing evidence that mental health can be directly improved through a healthy diet[111] and improved sleep.[46] Mental health workers benefit from attending to these lifestyle factors as much as their clients do and organisations can encourage and promote their staff adopting these practices.

Workplace safety for Indigenous psychologists

Aboriginal and Torres Strait Islander clinicians can experience unique stressors in a professional context, wherein their personal and cultural identity is routinely being brought into the process of their work with colleagues and clients. Aboriginal and Torres Strait Islander clinicians routinely experience racism, which presents a continual source of background stress. There are also workplace challenges as many work environments do not respect cultural differences, which affects both practitioners and clients, clearly undermining cultural safety.[112] It is also likely that Aboriginal and Torres Strait Islander clinicians have strong responsibilities to their family and community, which can be difficult for non-Indigenous workplaces to recognise. Furthermore, while their skills are highly valued, there are times when their cultural knowledge, or the ongoing process of being ‘called on’ to provide informal and formal consultation with non-Indigenous colleagues and Aboriginal and Torres Strait Islander clients, may not be acknowledged and can lead to burnout. Workplaces thus need to understand the importance and relevance of creating a culturally safe workplace.[112]

Section 2

Assessment and diagnosis

Assessment

The assessment is usually based on a clinical interview following DSM or ICD criteria but may be accompanied by other client-reported outcomes.[113] Failure to complete a diagnostic assessment may result in misdiagnosis, which may lead to an increased risk of ongoing challenges for the individual. Full comprehensive diagnosis is usually given by a trained professional. However, this guideline is useful for any clinician communicating about the diagnosis.

Most people with personality disorder report that receiving a diagnosis was an important part of their recovery journey, often marking the end of 'being stuck' and moving into a trajectory of seeking the right kind of treatment and beginning on a recovery journey.[32, 43]

Being diagnosed, if done well, can be a positive and helpful experience.[32] When diagnosing someone with a personality disorder, it is important to provide a clear and accurate explanation of the disorder, communicate positive ways to move forward, discuss possible treatment options, and offer hope that recovery is possible.

Steps for assessment[32]

The principal aim of an assessment is to gather information to make a diagnosis. However, establishing rapport is central to engaging the person in the assessment process and subsequent treatment. Early engagement also helps to promote the identification of other difficulties. The below steps may offer a useful guide to the assessment and diagnosis of personality disorder

1. **Explain, reassure, and connect**
   Explain why you are conducting the assessment and highlight how this is the first step to getting treatment that might help. Form an authentic connection and trust between 'two humans' rather than between 'doctor and patient.'

2. **Assess thoughtfully, in depth, and over time**
   Take the time to do a thorough assessment. This not only increases the odds of an accurate diagnosis but also allows treatment recommendations to be individualised. Offering a thorough assessment also helps the person feel like they are being taken seriously and that the clinician is truly invested in understanding and helping them. It is not recommended that clinicians make a diagnosis in an emergency setting, following a crisis, as this may not provide the safe and thoughtful environment needed for this to be understood and processed.

3. **Describe and collaborate**
   Clearly explain the outcome of the assessment in simple, sensitive, and jargon-free terms. Reference key areas of difficulty (e.g., affect, identity and relationships) as fundamentally human, rather than emphasising a diagnostic 'label'. Emphasise that there are a lot of people who have similar difficulties. Regularly stop to ask if it is making sense, if they have anything they would like to add, or if they disagree with something that has been said. Allow time to ask questions and process. Set realistic expectations of outcomes. Change is difficult and takes time but reinforce that recovery is possible.

Communicating a diagnosis

Take time to explain the diagnosis. It may be the first time that the person is hearing about personality disorder. Be aware that receiving a diagnosis of personality disorder can come with a range of responses. It is important to discuss the diagnosis regardless of the expected reaction. Not informing someone of a diagnosis reinforces stigma and may prevent appropriate intervention. If available, involve a peer worker or carer to ensure the person feels supported and understands the information provided.

Discuss symptoms or conditions that may be co-occurring or differentiated from personality disorder such as depression, trauma, chronic pain, psychosis, substance use disorders, anxiety disorders, neurodevelopmental disorders and eating disorders.

Diagnostic feedback script[114]

Basic steps:

- Set the agenda (e.g., “today we’re going to talk about the assessments you completed and your diagnosis”).
- Review the main symptoms the person has reported. It can be useful to go through the diagnostic criteria to discuss how each criterion makes sense to the person.
- Talk through the name of the personality disorder and provide the person with information.
- Review what is known about treatment for the disorder (e.g., “we know a lot about personality disorder and the different treatments. We can talk together about what might be helpful for you.”).
- Advise the person to be aware of misinformation regarding the diagnosis, including information that may be sourced from the internet.
- Answer any questions.

Example script:

“Now that I have a sense of what has brought you here, I’d like to discuss the symptoms you’ve described to me today. You told me that recently you’ve been experiencing these symptoms ____ and that you’ve been feeling ____. These symptoms and feelings cluster together into a syndrome. There’s a name for what you’ve described, and it’s called ____. This typically consists of symptoms like _____. People with this typically feel like ____. We know a lot about it including how to treat _____ effectively.

There is a lot of information available about personality disorders. However, some information you may find on the internet or on blogs can be incorrect. I’d be happy to help you find good sources of information. Do you have any questions or is there anything you’d like to know at this point?”

Give people information about personality disorder

Psychoeducation about personality disorder can be a critical clinical tool to engage a client in treatment by offering a destigmatising framework in which to understand their current symptoms and in turn, can focus the care that the person receives.[115, 116] It involves providing people with information related to symptoms, the principles of treatment, and the management of difficulties.[117] Components of such psychoeducation sessions often include information about common difficulties individuals may experience, possible causes, practical skills to cope with difficulties, available treatment options, therapy expectations, and dispelling stigma.[118] Information provided may be adapted based on the needs and circumstances of each person. Furthermore, the delivery of information is to be considered depending on the person's preferred way of learning (e.g., verbal, visual, printed, online).

- Explain the diagnosis and its related difficulties to both the person with personality disorder and their carer.
- Explain how the interplay of genetics, environmental influences, and predisposing factors are related to the development of personality disorder in an affirmative and empathic manner.
- Explain that the development of personality disorder is influenced by a multitude of factors that may have been unavoidable (e.g., neurobiological factors, adverse early experiences, and attachment relationships) which can interrupt emotional, identity, and social development.[119] See below for more information on brain processes and treatment.
- Explain that people with personality disorder may have had traumatic early experiences (neglect, abuse, etc.), but this is not true for everyone.[2, 120]
- Outline that personality disorder is often misunderstood, and dispel misconceptions and stigma.
- Reinforce the message that recovery is possible to both the person with personality disorder and their carer.
- Provide written information and factsheets about personality disorder. See the Project Air Strategy website (https://www.projectairstrategy.org) for Fact Sheets and video resources relevant to individuals with a personality disorder and carers.

Provide treatment and/or referral

Discuss next steps. Outline that there are many therapies that are scientifically shown to help with these difficulties, and that recovery is possible. Help the person to access appropriate psychotherapy. Offer referrals to peer support (where available), telephone support, community mental health services, private psychologists, non-government organisations or support groups where appropriate. Offer a follow-up appointment or provide contact details so that they do not feel alone during this process. Advise caution against reading everything on the internet, and provide guidance to access helpful, positive, online resources that do not perpetuate stigma.

Inform the person with personality disorder and their carer about the limited efficacy of pharmacotherapy for personality disorder. Outline the pros and cons of hospital admissions, and situations in which hospital may be helpful or unhelpful. For example, brief hospitalisation during crisis can be helpful in keeping the person safe in the short-term, however repeated admissions may increase stigma, de-skill the individual in developing agency over managing their symptoms and be unhelpful in reducing distress in the long term.[120]

Discuss the involvement of carers

Discuss whether the person would like to inform their carers of their diagnosis. If so, discuss how you can best support the person in this process. For example, would it be beneficial to set up a meeting between you, the person, and their carer/s, or would the person prefer to inform them on their own? What resources could be helpful for the individual in having this conversation? Discuss the diagnosis openly with the persons carer, family members or support person if granted permission to do so.

It may be useful to provide the carer with Fact Sheets about diagnosis, treatment, and how the family can best support the person. See the below section 'Include carers' for more information.

Offer post-assessment support

Post-assessment support is particularly important when sensitive or traumatic material has been discussed. This can include out-of-hours phone support with mental health or crisis support services.

Explain brain systems in personality disorders

Neuroimaging studies have identified differences in people with BPD across several key brain systems,[121, 122] including:

- Prefrontal-amygdala circuitry, involved in emotion regulation and threat detection.
- Default mode network (DMN), linked to ways in which the person thinks about themselves.
- Mentalisation-related regions, which support understanding of one's own and others' thoughts and feelings.

These differences highlight the neurobiological challenges for people with personality disorder in core difficulties of affect, identity and relationships.

Brain systems involved in emotion regulation, threat detection, and social cognition develop over childhood and adolescence. The way these develop is influenced by genetic inheritance and temperament, combined with early experiences. For example, early experiences of inconsistent care, trauma, neglect, or chronic stress can influence how the brain and body respond to perceived threat. This can impact the way key systems involved in regulation, attention and behaviour develop over time. These changes can be thought of as adaptations to early environments, even if they create challenges in adulthood.

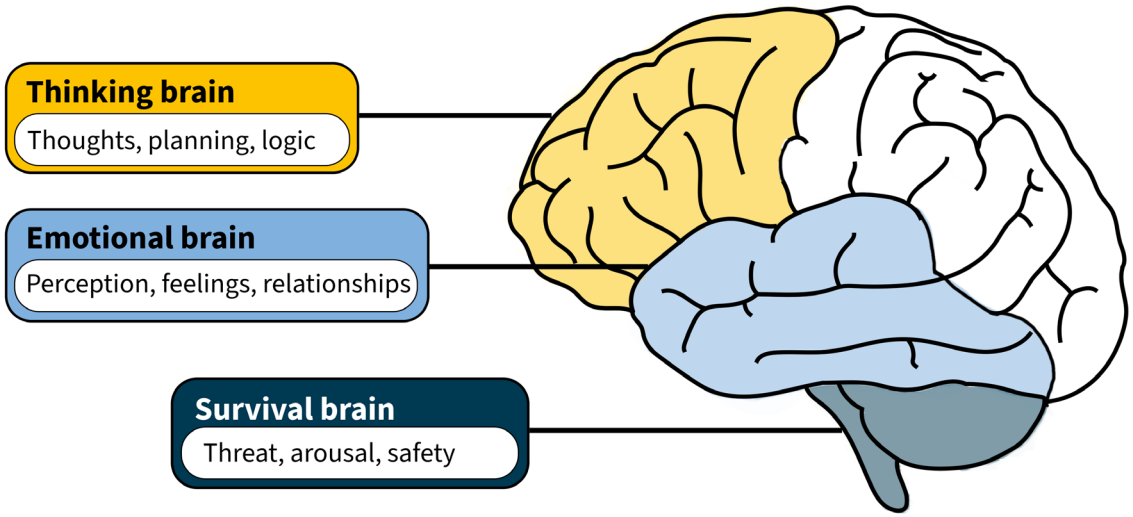
Feeling safe is a prerequisite for higher-level cognitive and emotional processing, and effective psychotherapy. Neuroscience often conceptualises the brain as three interconnected systems:

1. **Survival brain**
   Subcortical and limbic structures (e.g., amygdala and hippocampus) that respond automatically to perceived threat. These areas prioritise self-protection over learning or connection. Safety is foundational for psychotherapy and is defined not only by external observation, but by what the person feels in their body and nervous system. This is closely linked to physiological systems (the autonomic nervous system ANS and hypothalamic-pituitary-adrenal HPA axis), which regulate heart rate, alertness, and hormone release. Chronic stress or early adversity can make these systems overactive, shaping lifelong patterns of heightened vigilance, emotional sensitivity and reactivity to perceived threat.

2. **Emotion brain**
   Processes and regulates feelings, arousal, and social-emotional cues. Dysregulation in this system can make emotional responses intense or difficult to manage, particularly when the survival system remains hyperactive.

3. **Thinking brain**
   Cortical regions that support reflection, planning, and decision-making. Effective engagement of this system requires that survival and emotion systems are relatively regulated.

Simple categorisation of brain regions relevant to treatment for personality disorder



Brain systems are not fixed.[123-125] Psychotherapy can help 'rewire' neural pathways, strengthening emotional regulation, resilience, and adaptive responses over time. Supporting the regulation of the ANS and HPA axis through safe, consistent, and attuned therapeutic experiences reduces the cumulative effects of repeated stress, enabling fuller engagement of cognitive and reflective processes.

Treatment engages the brain through top-down and bottom-up processing. These are complementary pathways that influence how the brain responds to information:

- Bottom-up processing begins with the body and senses, sending information from the nervous system up to the brain. Interventions such as grounding, breathwork, movement, yoga, and creative arts therapies target lower brain regions and the ANS to promote safety, regulation, and bodily awareness.
- Top-down processing begins with the thinking brain, using cognitive and language-based approaches like psychotherapy, psychoeducation, and reflective exercises to influence emotional and physiological responses.

Many people with personality disorders have heightened sensitivity in systems related to threat detection ('survival brain') and emotional arousal ('emotion brain'). Psychotherapy is most effective when it first helps stabilise these systems to enable fuller engagement of the thinking brain. By addressing survival and building skills to assist with emotion regulation early in treatment, the individual can feel increasingly safe, validated and better able to pause and reflect before making choices. Addressing brain and body together supports sustainable change, recovery, and resilience over time.

Introduce practical skills to help manage difficulties

Research indicates that higher self-compassion in people with personality disorder predicts decreases in personality disorder features and depressive symptoms.[32] It is useful to teach people a range of skills that may be protective against personality disorder related difficulties. These can include:

- Explore and introduce daily self-care activities. Recognise both the value of self-care but also how this may challenge a person's beliefs about not deserving care, thus challenging expectations or experiences from the past. Topics to discuss can include taking time out, sleep hygiene, limiting substance use, exercise and good nutrition.
- Introduce the value of a 'here and now focus' on current difficulties and choices and how to problem solve them. This is irrespective of how small or trivial they may seem in the context of bigger challenges the person faces or the size of their difficulties from the past.
- Help the individual and their carer to take their lived experiences seriously. Invalidating their experience is associated with increased personality disorder difficulties.[126]
- Help the individual understand the importance and function of emotions, and how treatment can help them identify and understand these. This can help the person identify and plan for situations that trigger difficult feelings.
- Explain that difficulties in relationships are a common experience for people with personality disorder and relating this to the experiences of the individual. It can help to educate the person around strategies to improve their relationships, such as assertiveness skills and healthy boundary setting.
- Mindfulness, meditation, relaxation and acceptance techniques can assist the person to reduce their emotional dysregulation and help them focus on what is important now and in the future.[127] It should be noted that if the person has a reported or suspected trauma history, mindfulness meditation may be contraindicated until safety is established.

Section 3

Treatments for people experiencing crisis

Responding to a crisis

Working with people with personality disorder can be challenging, particularly during a crisis. When a person presents in crisis, they are generally at their most vulnerable. Symptoms are heightened and risk-taking or suicidal behaviours may be evident. An important therapeutic question may be “what happened to you?” This allows the person to explore the factors leading to the current crisis. Simply offering the opportunity to be listened to by a clinician who demonstrates compassion, empathy and interest, is very therapeutic and can help a person de-escalate.[128]

If self-harm and suicidal behaviours are not appropriately responded to, these behaviours can become more dangerous. However, paying excessive attention to these behaviours may inadvertently reinforce self-destructive behaviours. Focus on finding a balance between attending to the self-harming behaviour and its ramifications, with understanding the function of the behaviours. Overall, focus on the interpersonal and personal factors, rather than the self-harm behaviours themselves. Some clients may want you to focus on the behaviours and injuries, but this may be because shame, grief and other emotions behind the acts are much more difficult to face. Being respectful, curious and interested in the person’s situation can go a long way to helping them tell you more about their challenges.

The following steps are recommended when supporting a person who presents in crisis:

Key principles for working with people with personality disorders

- Remain calm, supportive and non-judgemental.
- Avoid expressing shock or anger.
- Stay focused on what is happening in the here and now. Avoid discussions about the person’s childhood history as this is better addressed in ongoing treatment. If these themes are raised by the individual, offer a transparent rationale as to why these are best discussed in the safety of psychotherapy. An example script might be “I’m sorry to hear these things happened to you, but let’s focus right now on what we need to do today to help you.”
- Express empathy and concern. Be human and demonstrate kindness.
- Explain clearly the role of all staff involved including how, when and what each will be doing to support the person.
- Conduct a risk assessment. Remember, the level of risk changes over time, so it is important to conduct a risk assessment regularly.
- Make a follow-up appointment and/or refer the person to an appropriate service. Ensure you have correct information regarding possible wait times and the process of intake.
- After the crisis, ensure that the follow-up appointment and referral was successful.

Conducting a risk assessment

A risk assessment is conducted to:

- Identify risk and protective factors.
- Elicit suicidal thoughts, plan, and intent.
- Guide decision-making.

Discussing risk with a client may also decrease the risk of suicide and repetition of self-harm because the person's challenges are shared and understood. When conducting a risk assessment, give attention to each of the following:

Risk assessment checklist

- Distinguish chronic from acute risk. Does the current episode follow a chronic pattern, or does it represent an escalation in acute risk and lethality? This will help determine how serious the risk is now.
- Be aware that if chronic risk is treated in the same way as acute risk (e.g., use of hospitalisation), suicidal behaviours may escalate. Include the basics of a risk assessment: Is the person thinking about self-harm/suicide? Does the person have a plan to self-harm/suicide? Does the person have intent to self-harm/suicide? Does the person have access to the means to self-harm/suicide? How lethal are the means to self-harm/suicide?
- Identify static and dynamic psychosocial risk factors. Examples of static risk factors are young chronological age, male gender, recent self-harm or previous history of self-harm or suicide attempts, family-history of self-harm or suicide attempts, or suicide in the person's peer group. Examples of dynamic risk factors are current relationship problems, domestic violence, transient homelessness or financial difficulties. This will help to determine how the risk has changed over time and what factor/s precipitated the person's escalation in risk. It is also important to identify what supports the person has in place.[33]
- Perform a mental status examination (MSE) and identify the existence of any key factors. This may include depression, hopelessness, thoughts about suicidal intent, whether a suicide plan exists and if the person has access to the means to carry it out. People who present in an uncommunicative or dissociative state are at higher risk and require prompt assessment and care.
- Identify if there is risk of harm to others, including the welfare of any dependent children.
- Clearly document your risk assessment including the MSE. Document the how and why of your reasoning, not just the level of risk. Consult with senior colleagues and have decisions regarding risk reviewed by senior staff.

Acute risk

Acute risk refers to the very real risk of a person completing suicide. Characteristics of acute risk may include:

- The person has a clear plan for suicide.
- The means by which the person intends to die are potentially lethal.
- The person has access to the means, or can readily gain access to the means, to enact the plan.
- There is nothing to suggest hope of the person changing their mind.
- The person expresses feelings of hopelessness regarding the future.
- Delusions may be present, causing the person to believe they must die

Responding to acute risk

If the person is deemed to be at acute risk, the following steps are recommended:

- Identify the person's psychosocial support system and contact their support people, including their primary clinician and carer, and discuss the treatment plan and crisis intervention. Advise the individual that you are contacting their next of kin in an empathic and supportive manner, with a transparent and clear rationale.
- Avoid overprotective responses that are related to staff anxiety, as opposed to the person's risk.
- Consider a brief hospital admission to contain the crisis. Ensure that the goals of the admission are clear and collaboratively agreed upon with the individual from the outset.

Immediate interventions for a suicidal person

- Do not leave the person alone. If they leave, call emergency services immediately.
- Reduce access to the means of suicide (e.g., if the person has stockpiled medications, talk through whether they are able to give the medications to their pharmacist).
- Consult with senior staff.
- Inform others and gain support (e.g., from the person's medical practitioner, crisis team, mental health service, hospital, family members, carers or others).
- Provide a clear explanation to the person of the steps you are taking.
- Never agree to keep a plan for suicide secret.
- Do not use guilt or coercion to guarantee safety.
- Find out what and who has helped in the past.
- Establish a Care Plan.

Managing risk

If the person is not well known to the clinician or service, it is recommended that a conservative risk assessment be undertaken. Some people also have unusual or unrealistic ideas and beliefs about what would follow their suicide (e.g., “I would be able to see everyone crying at my funeral”, “I thought I’d finally feel calm or peaceful”, “everyone will be better off without me”). Where appropriate, it may be useful to explore and gently challenge these beliefs to see if the individual can identify reasons why these solutions are not the best ones to solve their problems. It is important to discuss hope and that these feelings will not always show up. Connecting with peer workers with lived experience can help the person understand the journey of these feelings.

Chronic risk

People with personality disorder may be confronted by ongoing thoughts of suicide. It can help to assess if thoughts are ‘acute’ (indicating a sudden worsening, usually due to recent events) or ‘chronic’ (part of a usual ongoing pattern). Clinicians need to be able to tolerate some chronic risk to be able to focus with the person on how to live a life worth living.

Responding to chronic risk

If the risk is assessed as chronic, the following steps are recommended:

- The individual may be offered an appointment with a clinician in the community. Some people will prefer brief treatment episodes where they can engage with a clinician to exclusively work on current symptoms. Engagement in long term treatment can help to work on personality and relationship issues. It is important to note that people with personality disorders are less likely to die by suicide whilst engaged in treatment.
- Where possible, ensure continuity of care. It is preferable for the person to see the same clinician each time they present to mental health services.
- Establish a risk profile over time. All information regarding the person’s risk may be forwarded to the primary treating clinician or team.
- The individual may not be admitted to hospital unless the risk is considered acute or potentially lethal, that is, a high level of risk. Where a person is admitted to hospital, clear treatment goals should be identified from the outset, and where possible the admission is brief.
- Where possible, encourage the individual to communicate their needs. This could be achieved through any medium (e.g., verbally, written, creatively) that the person prefers.

Tolerating risk

Given many people with personality disorder have a history of self-harm or previous suicide attempts, and many continue to engage in risk-taking behaviours, the evaluation of risk is not always clear. It is usual for clinicians to also feel anxious about the person's level of risk. Points to consider:

- Understand the reasons for self-harming behaviours including its function. For example, people frequently report self-harm as a means to feel physical pain, control feelings or overcome emotional distress, punish oneself for being 'bad' or worthless, express anger, feel numb or dissociate, overcome numbness, cope or self-soothe, or to prevent suicide. It can also be useful to decipher what the person is communicating by self-harming. For example, is the person attempting to evoke a response from another person and what are they communicating?
- After the person's distress has been validated, develop risk management strategies in collaboration with them. This requires active listening and identifying risk management strategies that are tailored to the person's preferences and needs.
- Acknowledge that part of the therapeutic engagement (whether short or longer term) is about finding reasons for living. There may also be times when the person's desire to die needs to be acknowledged. If this arises the role of the health professional is to model our inherent ability to hold 'two truths': that you can experience a desire to die, at the same time as identifying values-based reasons for living.
- Be aware of high risk times or situations, for example, people with personality disorder are known to be at risk of suicide around times of stressful transitions (e.g., discharge from hospital).
- Collaboratively construct a case formulation letter differentiating acute from chronic risk and agree upon a safety plan.

People presenting with risk-taking behaviours can evoke strong reactions in clinicians. This can manifest as either strong identification with a desire to help, or as frustration and a tendency to dismiss their concerns. In such situations, clinicians may treat clients differently from usual. This can result in clinicians enforcing rules and limits more strictly, or 'bending' clinical guidelines to care for the person. It is highly recommended that clinicians seek clinical consultation to reflect on and manage these challenges.

Considerations for emergency and inpatient hospital settings

When a person presents to an emergency department (or hospital) in crisis, the role of hospital staff is to assist the person to stabilise and demonstrate compassion. It is important to take the person's distress seriously and try to understand the challenges they are facing. The process of listening and showing compassion helps the person to feel validated. This allows the possibility to discuss here and now problems with a view to addressing both immediate needs and short term plans for care.

In many cases, it is preferable not to admit them to hospital, but to engage the person in community based care, particularly if it is provided quickly (e.g., within 1-3 days of crisis presentation). The Project Air Strategy has developed a brief intervention[129] based on one to four sessions of psychotherapy to support a person through a crisis as an alternative to hospitalisation, as described in the brief therapy section.

Self-harming behaviours and repeated presentations

People with personality disorders may engage in high-risk behaviours, resulting in repeated presentations to hospital. Dealing with multiple self-harm and repeated suicide attempts can be extremely challenging for staff. It is also possible to become complacent when a person presents frequently with the same symptoms or behaviours. Self-harm and suicidal behaviours can be the only way that some people know to communicate their distress at that time.

The overall goal is to help link the person with evidence-based psychotherapy in the community, where they can establish a relationship with a clinician and work on better managing their distress and difficulties. Over time, and once the therapy has begun to establish greater security and stability for the client, this usually helps to prevent repeat crisis presentations and the need for hospital episodes.

Self-harm is often:

- Used to help manage overwhelming and intense distress or to provide immediate relief from negative or painful emotions.
- Used to punish or treat the self as worthless.
- Associated with high levels of impulsivity.
- Performed in secret and presented in crisis.
- Performed after a triggering event such as separation, an experience of rejection, loss or failure, or when the person feels alone.
- Accompanied by endorphins which means some people don't feel any associated pain.
- Followed by shame and remorse.

When a person with personality disorder presents to hospital, including an emergency department, the following steps are recommended:

- Respond to the medical and physical needs of the person first. Provide clear explanations about medical treatment.
- Conduct a thorough risk assessment.
- Determine whether the person requires a hospital admission, and if so, what the goals and potential timeframe of the admission would be.
- Once the person's level of risk has stabilised, determine if the person is currently engaged in longer term treatment with a health practitioner, and if so, refer them back to their primary treating clinician. If they are not currently engaged in longer term treatment provide them with a referral to a community based brief intervention service where possible.
- After the person's level of risk has stabilised and they have been referred for a follow-up appointment with a brief intervention clinic or primary treating clinician, they may be discharged.

Attempt to avoid:

- Discussing issues related to childhood relationships. If these themes are raised by the individual, offer a transparent rationale as to why these are best discussed in the safety of psychotherapy.
- Paying a lot of attention to the injury itself (e.g., beyond the minimum amount required to stabilise the person), as this may reinforce self-harming behaviours. It is more fruitful to focus on the triggers that led to the crisis.
- Involuntary admissions, as it is best to have the person's consent including agreement on the goals of the admission which may be outlined in a Care Plan.

Hospital admissions

Hospital admissions for people with personality disorders, particularly involuntary admissions, present numerous challenges to the development of rapport and the therapeutic alliance. Involuntary admissions undermine the crucial goal of treatment in personality disorder; to help the person become a partner in taking agency for their progress. However, at times, people in crisis may require an admission as part of a comprehensive treatment approach. Any hospital admission may be brief and goal-directed. Goals could include stabilising the person's mental state, helping the person regain a sense of control over their life, or making preparations for future treatment. There is evidence that brief planned hospital admissions with specific goals can improve outcomes for people with personality disorders.[130] Conversely, prolonged hospital admissions may exacerbate symptoms by reducing autonomy.[128]

Successful outcomes of hospital admission are influenced by the ability of all treating clinicians to develop positive relationships with the person. This includes understanding that the person may experience difficulties in relating to others. It also helps to recognise the survival value of the person's behaviour. Lack of awareness of the aetiology of personality disorders can influence treatment in negative ways. Education and clinical consultation are recommended to encourage compassion and facilitate thoughtful treatment planning.

At the time of admission

- Identify the admission goals.
- Clarify what led to the crisis and subsequent admission.
- Consider other mental health conditions such as substance abuse, major depression and psychosis. This will influence the treatment and discharge planning.
- Record mental state and behaviour.
- Review the Care Plan or develop a Care Plan (if the person does not have one). It may also be useful to develop a Care Plan specifically for use in an inpatient setting. This can be kept in the person's medical record for future reference.
- Consult with the primary treating clinician, where one exists, to ascertain recent functioning and stressors.
- Involve support workers, peer workers, residential workers or family workers where possible.
- Plan discharge as soon as the person is admitted to hospital.
- Communicate mental state status and discharge plans with other clinicians and carers. Don't send the person home without telling someone first.

Key considerations for inpatient treatment teams

Further considerations for mental health inpatient unit clinicians include:

1. Preventing involuntary admissions

- Involuntary admissions can cause an exacerbation of symptoms.
- An alternative to an involuntary hospital admission is a planned brief hospital stay. This may assist the person to manage increased self-harm or suicidality.
- The Care Plan may include an agreement stipulating that the person can, at their discretion, use the hospital for a specific period of time.
- Often there can be difficulty establishing a predetermined hospital admission plan with hospital staff, however, once it has been established it does tend to decrease the number of bed days in the longer term.

2. Setting limits

- Firm limits for challenging behaviours are crucial. These include expectations regarding daily routine with a clear rationale for the therapeutic utility.
- Limits and consequences should be clear to all staff and be supported by all staff involved in the person's care.
- Firm limits may not be used as a licence for health professionals to engage in punitive behaviours such as punishment, judgement or coercion.
- Limits ensure the person is not considered to be 'special' and an exception to normal ward procedures, rules and routines. Consistency between staff is important and if there are considerable variations this needs to be addressed promptly.

3. Clarifying roles

- It can be helpful to clarify each staff member's role within the hospital unit to provide structure for the person with personality disorder and the treating team.
- Remember that is it is beneficial for the person to have psychotherapy with just one clinician. Because psychotherapy generally lasts longer than the length of admission, this clinician is best placed in the community. Hospital clinicians can support psychotherapy by using consistent language and displaying a consistent attitude.

4. **Managing difficulties within the treating team**
    - Conflict within the treating team can arise which can affect intra-ward dynamics.
    - Staff from different and similar disciplines may hold strong opinions about the management of people with personality disorders. Recognise these differences and allow time for discussion to reach a consensus, where possible.
    - All staff may conceptualise themselves as part of the treating team and work together to avoid relationship problems within the team.

5. **Preventing frequent admissions**
    - Well-considered, collaborative discharge plans are the most effective way of reducing readmission, especially if they engage the person in community based therapy. Discharge planning often needs to be considered from the outset of admission.
    - Comprehensive discharge plans that include a clear structure for follow-up, strategies for dealing with a crisis, names and phone numbers of people to contact and psychosocial plans to support the person's re-connection with their community are crucial.

Referral for follow-up services

The following steps are recommended when referring clients for follow-up services (e.g., brief intervention, community mental health, or a private clinician):

- The person may be referred to a follow-up service prior to discharge.
- Provide the person with details of the new service they are being referred to. Ideally this may include a map and a telephone number to contact in a crisis.
- Provide the person's carer with the same information about the new service.
- Send the new service a copy of the risk assessment and a discharge summary within 24 hours of discharge. Include current contact details for the person and their carers.
- Encourage the new service to contact the person within 72 hours of discharge.
- Encourage the person with personality disorder to contact the new service if they haven't heard from them within 72 hours.
- Send a copy of the discharge plan and referral to the person's medical practitioner and any other relevant service providers.

Collaboration with carers in the hospital setting

Collaboration with carers is enhanced when, with the consent of the client, they are:

- Contacted within 48 hours of admission to share information.
- Given information about the person's diagnosis, strengths and management strategies.
- Involved in goal setting and discharge planning.
- Offered a feedback and review session if the admission is longer than 5-7 days.

Considerations for medical staff

The following aims to support medical staff (e.g., medical practitioners, psychiatrists, staff specialists, emergency department doctors, and other medical officers) provide optimal health care within the pressures and constraints of health settings. The most effective treatment of people with personality disorder requires clear, consistent communication, collaboration and compassion. An integrated health care approach involving all health care professionals in partnership with the person with personality disorder is recommended.

For new people entering treatment, the following guide may be useful:

- Review the person's Care Plan.
- Ask for details relevant to assessing and treating the immediate medical issues only.
- Avoid discussing issues related to childhood, relationships or other life situations. If these themes are raised by the individual, offer a transparent rationale as to why these are best discussed in the safety of psychotherapy with their primary treating clinician.
- Provide the person with a clear explanation and rationale about medical treatment and what they can expect. Offer time and space to answer any questions the person has about their medical treatment as for any other client.
- Contact mental health services or other workers involved in the person's care at the point of admission. Ensure the medical team has the correct contact information and details about the person's care.

Considerations for optimal care

Approach: People with personality disorder may have experienced stigma, rejection, abuse, or trauma related to their disorder. In some instances, the diagnosis of a personality disorder has been utilised to deny access to services, which further compounds rejection and stigma. When working with people with personality disorder:

- Maintain a compassionate, empathic, non-judgmental approach.
- Be clear, consistent and reliable.
- Be aware of your own views and biases about people with personality disorder, including how these can affect your interactions with people with personality disorder, or their carers.

Refer: People with personality disorders may need specialist longer term treatment. However, treatment is best conducted when all health care providers work in collaboration and share a common treatment plan (e.g., medical practitioner, practice nurse, physician or other medical staff).

Diagnosis: It can take time to accurately diagnose a personality disorder. It may be mimicked by other problems such as substance abuse or hypomania. A second opinion regarding diagnosis may also be useful.

Medical history: It may be useful to discuss any recurrent or ongoing medical issues with the primary treating clinician or local community mental health service, with the person's written consent. It is important to consider co-occurring physical conditions.

Medical and dental care: People with personality disorders may neglect their medical and dental needs, typically due to the stigma experienced within health care settings. In some circumstances, it may be best to have a gender-congruent practitioner, a carer or nominated person present during examination.

Boundaries and structure: Due to the symptoms of the diagnosis, people with personality disorder may miss appointments, request appointments at inconvenient times, or attend the clinic without an appointment. Consistent, clear and predictable interactions with all staff are crucial. In general practice, the function and role of the medical practitioner may be made clear. A shared care strategy is highly recommended. This may include agreement between the person, practice manager, reception staff, nurses and the medical practitioner outlining when and how the person can access care. These strategies can also be employed in community mental health centres and other settings.

Plans for when and how to access emergency or crisis care are critical. For example, if the person's self-harm is life threatening, the plan may recommend treatment in the emergency department and not with the medical practitioner's clinic. These plans are most successful when made collaboratively when the person is functioning well and may require review periodically.

Health care professionals are encouraged to review the person's Care Plan when necessary. If there is no Care Plan in place, develop an interim plan and refer the person for a full psychiatric assessment.

Considerations for using medication

Pharmacotherapy is not recommended as a primary treatment for personality disorder, as it does not change the course of the disorder. Medication may be used to target specific co-morbid symptoms, but it is important to avoid polypharmacy. Ensure medications are trialled sequentially in a systematic way that includes regular review. This review may also examine whether the benefits of using the medication outweigh the risks. Clinical conditions (e.g., major depression) are legitimate foci for pharmacotherapeutic intervention and require appropriate treatment. However, it is important to consider that some symptoms may be better accounted for by the personality disorder instead of a co-occurring mental illness.

Relational approach to prescribing

Therapeutic principles apply to prescription practices. For example, the person may be encouraged to work in partnership with the doctor to make an informed choice about medications. To achieve this, it is important to be clear about both the specific goals of prescribing and the therapeutic targets. Encourage the person with a personality disorder to report any side effects of medication. This will assist in a realistic review of its efficacy and benefits and support a collaborative decision to end an unsuccessful medication trial. Remind the person about the poor evidence for the use of pharmacotherapy for personality disorders (including atypical antipsychotic agents and mood stabilisers) and the corresponding stronger evidence base suggesting psychotherapy is more effective.

Both medical practitioners and people with personality disorders may hold strong views about the likely efficacy of pharmacotherapy and these can have both positive and negative effects. Some examples include:

- High expectations about the likely efficacy of medication at the commencement of treatment can cause problems when the expected improvements are not forthcoming.
- Some people with personality disorder are unwilling to explore pharmacotherapy when other treatment methods have proven ineffective.

The interpersonal challenges involved in the treatment of people with personality disorder may appear to complicate medical decisions. The medical practitioner can be at risk of prescribing, or failing to prescribe, pharmacological agents based upon their own biases and interactions with the person. For example, the medical practitioner who is idealised by the person may prescribe pharmacological agents when asked to do so, while one who is devalued may withhold medication. To prevent this pattern, it is important to consider the evidence base for prescription based upon the person's presentation and take a team approach wherever possible.

When considering a particular medication, plan for its decrease and cessation. Remember that psychotherapy is the primary treatment for personality disorder.

Developing a Care Plan

The aim of the Care Plan is to identify and gain agreement between the person with personality disorder and the clinician on:

- The person's goals.
- Crisis survival strategies.
- Others involved in the person's care, including health professionals and carers.

The Care Plan is designed with the single principle to help orient the person to how to live a life worth living. This includes how to get through a crisis without making it worse, identifying core values by reflecting on what is important to the person in the short and longer term, and documenting the valued people that can be supportive on their recovery journey. A collaborative approach is important to developing the Care Plan and extends beyond the involvement of the clinician and the person with personality disorder to include other health professionals, as well as families and carers wherever possible.

A collaborative Care Plan helps to:

- Manage and reduce the person's level of risk.
- Increase the person's level of safety and their confidence in their ability to remain safe.
- Wherever possible, offers choice and autonomy.
- Provide a structured goal-oriented safety plan that helps to reduce anxiety of the person and those involved in their care.
- Identify strategies on how to most effectively reduce distress for the person.
- Clarify what has been done in the past that has not helped to reduce the person's level of distress or has made it worse.
- Engage the person in the treatment process and encourage autonomy, providing additional support to people who may have not developed a sense of agency over their life decisions previously.
- Support the person and the clinician to navigate their way through a crisis.
- Support quality treatment and support decision making.

A collaborative approach helps the person to:

- Be empowered and motivated to work toward specific goals.
- Feel heard and respected.
- Foster a sense of hope for the future.
- Become actively involved in, and take greater responsibility for, their treatment.
- Create greater understanding and awareness of the diagnosis, triggers and how to recognise and manage potential crisis situations.
- Use the strategies in the Care Plan across contexts and across several treatment settings with different providers.
- Improve decision making in crisis and distressing situations.
- Reduce hospitalisations.
- Maintain an awareness of progress made over time.

A collaborative approach helps the clinician to:

- Share responsibility for treatment across several service providers and/or health professionals.
- Build a relationship with the person with personality disorder based upon mutuality, trust and respect. This has been shown to increase adherence to treatment, continuity of care and the person's satisfaction with the services offered.
- Enhance the quality of material in the Care Plan.
- See the individual as an active agent of change within their own care trajectory.
- Identify stressful interactions as possible symptoms of the personality disorder.

A collaborative approach helps the carer to:

- Feel included in the treatment process and, thereby, motivate, encourage, and support the person with personality disorder.
- Identify clear tasks that have been identified as helpful for the individual.
- Reduce any sense of helplessness and hopelessness.
- Strengthen their relationship with the person with personality disorder and provide a framework for them to come together as a team.

The Care Plan is considered a working document that evolves over time and may always be developed and reviewed using a collaborative approach. See the following page for an example Care Plan that can be used with both adults and young people.

Care Plan

Name: **Clinician Name:**

My main therapeutic goals and problems I am working on

(1) In the short term

(2) In the long term

My crisis survival strategies

Warning signs that trigger me to feel unsafe, distressed or in crisis

Things I can do when I feel unsafe, distressed or in crisis that won't harm me

Things I have tried before that did not work or made the situation worse

Places and people I can contact in a crisis:

Lifeline: 13 11 14 Emergency: 000 Kids Helpline: 1800 551 800 Local Service:

My support people *(e.g., partner, family members, friends, psychologist, psychiatrist, teacher, school counsellor, social worker, case worker, GP)*

Name	Contact Details	Role in My Care	OK to Contact?

Signature: **Clinician's Signature:**

Date: **Date of next review:**

Copy for the: Client/Clinician/Emergency/GP/School/Case Worker/Other (please specify)

The following steps are recommended when developing the Care Plan

When: The Care Plan may be developed when the person presents to hospital, a crisis or brief intervention setting, or early in the assessment process. It may be reviewed and updated on a regular basis including on admission to a treatment program or service.

Who: The primary treating clinician should take key responsibility for initiating the development and regular review of the Care Plan, which is best achieved in collaboration with the individual. The person may be encouraged to take responsibility for physically writing the Care Plan whilst collaborating with the clinician, noting this is not always possible or supportive. Carers may also be involved in this process. Adopting a collaborative approach also extends to the consultation of colleagues (e.g., reviewing the Care Plan at case conferences, individual and group clinical consultation, and team review meetings). This ensures a multidisciplinary approach to treatment and allows for independent input into the Care Plan. Specialist services can also be consulted for input where appropriate; either services already involved in the person's care or those that could offer new assistance.

Identify both short and long term goals

Goals may largely be determined by the person to provide a general guide and direction for treatment. They should be relevant and meaningful to the person and able to be reasonably achieved. Sometimes it can be beneficial for the goals to remain vague so the person's sense of hope or self-esteem is not further diminished if they do not meet a more specific goal. At times, people with personality disorder may experience difficulties identifying self-directed goals. Clinicians may benefit from offering support and guidance. It is important that the attainment of goals, including partial attainment, is recognised and reinforced.

Identify situations that trigger distress or risk

Identify the potential situations or events that trigger a level of heightened risk or distress in the person. The Care Plan may address both long term and acute risks and be explicitly related to the plan for treatment to ensure continuity of care. The seriousness of the risk should not be underestimated, particularly in people who make frequent suicide attempts, are identified as experiencing chronic risk, or self-harm.

Identify self-management strategies that reduce distress and risk

Identify non-harmful behaviours that may help to reduce the person's level of distress and risk. If the person is unable to identify any helpful strategies, the clinician may provide prompting, psychoeducation and experiential guidance in exploring ideas. The following examples have been reported by people with personality disorders as useful ways to reduce their risk:

- Avoiding specific triggers or cues, including certain people, places, times and situations.
- Doing an art or craft activity like drawing, colouring or painting.
- Holding ice.
- Phoning or texting a friend.
- Calling or texting a support line.
- Taking a cold shower.
- Listening to music.
- Sucking on a strong peppermint.
- Stroking a pet.
- Cuddling a teddy bear.
- Going for a walk or run.
- Creating lists in the notes app on their phone (e.g., goals for the future, letter to my distressed self, reasons to continue to work on recovery).
- Using apps that are designed to reduce distress or urges to self-harm.

Identify strategies used in the past that have not been helpful, or have made things worse

Identify strategies the person has utilised in the past that have not been helpful in reducing their level of distress or risk. These behaviours often provide short term relief whilst creating longer term unhelpful consequences, such as self-harm or substance use.

Identify who is a contact in an emergency

Identify a list of services to contact in an emergency including 24-hour service providers. This includes contact details (phone numbers and addresses) of the mental health crisis team, telephone crisis counselling service, services supporting particular groups (e.g., for young people, LGBTIQA+, or First Nations), together with advice about when the person may want to contact each one.

Identify others helping with treatment

Identify the health professionals and carers, including family members and friends, who are involved in the person's care. Include their contact details and the role they play in supporting the person with personality disorder.

Consent

Determine whether the person with personality disorder gives consent for the clinician to contact these support people and what can be discussed with each of them. Consent can be provided by writing ‘yes’ or ‘no’ in the section of the Care Plan marked ‘OK to contact?’, however other forms of written consent are also acceptable. As relationships and engagement with services can change over time, it is best practice to review consent with the individual at each episode of care and during treatment. It is not unusual for people with personality disorder to refuse to identify or involve their carers in their treatment. They may change their mind about their carer’s level of involvement. These fluctuations may or may not be attributed to their mental health condition. Consent on the Care Plan is not an indefinite ‘blanket’ consent.

Set a review date

The Care Plan may be reviewed on a regular basis including at least once every three months. More frequent reviews are recommended in the early stages of treatment to assist the clinician and person to develop a greater awareness and understanding of the issues. It is not unusual for a Care Plan to be relatively brief in the early stages of treatment. Ongoing reviews will ensure that changes in personal relationships, goals, potential triggers and strategies that have proven beneficial in reducing distress and risk are well documented.

Be accessible across services

The original Care Plan may be given to the person and copies kept in their medical record. With the person’s consent, copies may be distributed to the emergency department, other health professionals involved in their care, and carers.

There may be lack of agreement among health professionals regarding the Care Plan. These disagreements are not uncommon and typically reflect the treatment challenges and complexities, and various responses and reactions to the client by health professionals. A case conference may be held to clarify the issues and seek a resolution.

Care Plans for different situations

It may be useful to have several Care Plans that are applicable to different settings (inpatient or outpatient). For example, some crisis survival strategies used in an outpatient setting may not be workable or appropriate for an inpatient stay. In this instance, it may be useful to have a separate Care Plan for hospital settings.

Section 4

Individual psychotherapy treatment in the community

Key principles

Psychotherapy is the treatment of choice for personality disorder

Research has established that well delivered psychotherapy leads to substantial and sustained improvements for most people.[131] There is no evidence or consensus regarding the duration of therapy,[131] with research suggesting brief, medium and longer term therapies all work well. In general, people with lived experience emphasise the importance of persistence, that continuing on a recovery journey relies on an accumulation of different therapy experiences across time.[44]

Manualised approaches

There are several structured and manualised brand name therapies that have been evaluated in randomised controlled trials in longer term therapy settings (usually at least one year duration).[22, 132, 133] In general, these derive from psychodynamic, emotion-focused experiential, and cognitive-behavioural principles, or often a combination of all of these.[134] Dialectical Behaviour Therapy (DBT)[133, 135-137] and Mentalisation Based Therapy (MBT)[138] have the largest number of studies, although several other therapies have been established to be effective including Transference Focused Psychotherapy (TFP)[139] and Schema Focused Therapy (SFT).[140] There are also group therapies used to add onto individual psychotherapy, including Systems Training of Emotional Predictability and Problem Solving (STEPPS),[141] and Emotion Regulation Group Treatment. Other therapies that have evidence of effectiveness include the Conversational Model (CM),[142] and Cognitive-Analytic Therapy (CAT).[143] It is also likely that other therapies that have been developed to work with complex mental health conditions will be shown to be effective in the future, including approaches such as Meta-Cognitive Therapy (MCT).[22] In addition, stepped-care whole of service approaches have also been shown to be effective,[37] including brief interventions immediately following a crisis.[36, 144] There is also growing evidence for group therapies that include peer and clinician co-leaders,[145] art therapy approaches[146, 147] and groups for people diagnosed with personality disorder who are also parents.[148]

Evidence based guidelines

Different models of therapies are increasingly converging on the same principles and share highly similar components. Guidelines-based treatment using a relational model (e.g., these guidelines) and Good Psychiatric Management[149] are two examples of the integration of effective psychotherapy techniques. In the broader mental health field, services are increasingly implementing whole-of-service stepped care models to offer flexible responses based on client need.[21, 37, 150-152] Therapies of different durations have been found to be similarly effective. This means that collaborating with the client to determine the best duration of therapy for their needs when they need it is more important than just duration alone. In addition, not all people are seeking long term therapy but rather are looking for specific support at the time to help them regain a sense of control of their mental health - thus intentional brief, medium term and longer term therapies may be planned depending on client need and preference.

Common factors

Although there are many brand name therapies, most have not been compared in well controlled clinical trials, and most contain the same or highly similar ingredients and thus are expected to perform equivalently. In general, experts in the field and researchers agree that the brand name of the therapy is far less important than the skills of a clinician.[153] Indeed, research into common factors in psychotherapy suggests that up to 70% of treatment outcomes can be attributed to elements shared between therapeutic approaches including therapist factors such as the therapeutic alliance, and client related factors including expectations. Notably, the therapeutic alliance alone has been found to account for approximately 30% of the variance in client outcomes, whereas specific therapeutic techniques, unique to each modality, contribute a more modest 1-7% of outcome variance.[153, 154] This means a significant proportion of the benefits of psychotherapy come from the relationship between the client and the clinician.

Key principles for psychotherapy with personality disorder

Five common characteristics of evidence-based treatments for personality disorder have been identified by experts by consensus:[155]

1. Structured (manual directed) approaches to prototypic personality disorder problems. For example, therapists are encouraged to follow evidence-based guidelines, or a manual or approach developed to treat personality disorder.

2. Clients are encouraged to assume control of themselves (i.e., sense of agency). For example, the basic therapeutic stance is to work with the client in a way that encourages their capacity to make choices - rather than seeing them as helpless. It can be useful for the therapist to maintain a ‘curious stance’ (‘not knowing stance’) encouraging the person to openly think and reflect about their feelings, intentions and actions, thus encouraging self direction.

3. Therapists help connections of feelings to events and actions. For example, the therapists’ role is to help the client actively develop their sense of themselves in the world. This is done by helping the person understand their own and others’ feelings, intentions, and actions.

4. Therapists are active, responsive, and validating. For example, therapists model a collaborative, active and personable stance that allows the person to feel understood and to develop trust that the therapist is genuine, honest and safe.

5. Therapists discuss cases, including personal reactions, with others. For example, therapists recognise that outcomes are improved when they are supported by trusted colleagues with regular opportunities to debrief and get guidance about their work.

These common elements include having a clear and transparent framework focused on personality disorder difficulties, with agreement on the goals. The approach needs to recognise and address fluctuations in engagement, attendance and motivation as expected struggles, to be met with patience, persistence, and compassion. The voice and preferences of the individual must be at the heart of the service that is provided, including ensuring culturally responsive care.[6] Finally, a relational, recovery-based approach recognises that psychotherapy works best when there is attention to the broader 'love and work' spheres in the person's life, including stability of accommodation and finances, opportunities for engagement in study or work, and an attention to finding opportunities for the person to love and feel loved.[44] This is further discussed in Section 1, 'Fundamentals'.

Setting expectations about care

Good communication is core to working with people with personality disorder. Clear, detailed conversations need to occur with the person from the first interactions. These include information about what will occur, how long appointments will be, what the person can expect, how you will work with the person, others who may be involved, and when the service will end (if known). The conversations also need to include boundary setting so the person understands the limits to what will happen during your time together. These can include:

- Discussions about availability and methods of contact.
- Describing what will happen and the expected duration.
- When the service will end and how this will be managed.
- How escalation of symptoms will be responded to.
- How confidentiality and privacy will be maintained, and in what specific circumstances it will need to be breached and how this will look.
- Ways for the person to request further help.
- How to get help if the person is not satisfied.

Managing endings

Endings, discharges and referrals mark important transitions in a person's care. Especially for people with complex mental health presentations, these transitions and endings can be emotionally challenging and may bring up powerful feelings of being abandoned or rejected. Ending psychotherapy can present an opportunity to reinforce skills, normalise feelings, and acknowledge growth. For people with histories of relational trauma, having a 'good enough' ending can be a powerful experience, especially if it is done in a respectful, consistent and caring way.[156]

Many people have multiple experiences of seeking help.[157] If the person has complex mental health challenges, it is likely this will not be the end of their therapeutic journey. They may continue to work with other care providers or re-engage with services in the future. Normalising this and encouraging the person to seek further support is recommended. It can help to discuss the concepts of setbacks versus relapse, and to normalise and explore individual warning signs of a decline in mental health. A positive experience fostering agency in the process of ending the current treatment can help individuals feel empowered and more confident in seeking help in the future.

Treatment will most likely be a success if the ending is expected and well planned. Clinicians may help the person understand therapy is a temporary but supportive space in the here and now designed to build skills for future challenges. It is also important to explore and manage any expectations or emotions about ending the relationship. From the beginning of any therapeutic relationship, it is important to anticipate the ending as a natural and expected part of the process.

- Establish a clear therapeutic frame early in treatment, including the purpose, structure, and likely duration of therapy.
- Set an ending date, or at least set a review date, so that the treatment has an agreement and develops a commitment from both parties to work for a specific amount of time together. This is recommended to support emotional preparation and predictability. Decide on a specific date you will finish, rather than number of sessions, to avoid confusion if sessions are missed or extra sessions booked.
- Talk about the planned ending of therapy from the outset. Ensure people know the therapeutic relationship will come to an end at a mutually agreed upon point and revisit this regularly during therapy to normalise and manage expectations. It is recommended that a final session is planned in advance, so both the individual and the therapist have the opportunity to end the therapeutic relationship in a meaningful way.

People's reactions to endings will vary depending on several factors. Clinicians may be aware of potential risks including:

- Premature termination - therapy can bring up difficult distressing feelings, which the person may want to avoid. This can lead them to want to discontinue early. It is important to notice this and proactively talk about the person's experience and fears and adjust the approach to help them feel safe to stay.
- When treatment is coming to an end it is common for setbacks to emerge, such as increased urges to self-harm. The re-emergence of such feelings might relate to the persons worry about the ending and the loss of the support of the clinician. Talking about these feelings and recognising any worries about the ending can be very helpful. Sometimes the clinician needs to bring this up first, as it might be too difficult or out of awareness for the person during this time.
- Endings may bring up difficult feelings about previous losses or trauma. Historical feelings of loss, rejection, being abandoned or neglected can surface. Allowing space to recognise these painful feelings and being able to differentiate them from the therapy ending can be helpful.

It is important to recognise there can be many reasons why therapy comes to an end. Sometimes external factors interfere, such as moving away or difficulties attending. Other times, the goals of therapy have been reached and it's a healthy and positive step to move to finish therapy. Whatever the reason, setting aside some time to discuss the ending together is important.

Prior to the final session, it is important to plan for how the clinician and person may part ways and say goodbye. Sharing therapeutic letters, drawings or certificates of completion might be helpful, as can the simple exchange of reflections and feelings. The final session is still therapy so may allow time to discuss what is currently important for the person, as well as setting aside time to review progress, say goodbye and notice any changes or ongoing struggles.

Brief interventions: Working with people for up to one month

Brief therapy (typically 1-4 weeks) can be especially helpful in assisting a person who has been in crisis to regain safety and improve their mental health as part of a stepped care response. Outside of crisis presentations, brief work is likely to have only a small or modest impact on the personality disorder. Whilst accounts of past relationships and developmental challenges may be helpful in understanding the client, the treatment focus is on current relationships and improving choices to help live a life worth living in the here and now.

Note that Project Air Strategy has also developed a specific manualised one month brief intervention known as a 'Gold Card Clinic' for mental health services that includes care planning and how to connect with carers. This might be a good way to work with a client, particularly if they have recently presented in crisis.[129] This program establishes a predictable, coordinated and structured brief treatment approach for people with personality disorder experiencing crisis. Most importantly, the approach is designed to rapidly respond to a person seeking help, recommending the first therapy session occur between 1-3 days after a crisis presentation. It has been evaluated in various contexts and found to be highly effective.[37, 158] It can also be delivered in person and virtually,[159] and with adolescents.[160] Engaging with a brief intervention is associated with reduced general mental health symptoms, personality disorder symptoms, suicidal ideation, and improvements in quality of life.[36] Other benefits include shorter inpatient admissions, reduced re-presentation rates to emergency departments, and significant cost savings.[37, 158] Further details of this are provided elsewhere, including manuals, a guide for services on how to set up these clinics and associated resources.[129, 159, 161] The following is a general guideline for working briefly, whether it is part of a specific clinic or in any other consultation context where one-on-one therapy is provided.

Setting the frame: disuss the brief duration of the work

The overarching aim of a brief intervention is to support a person with personality disorder to address their current difficulties, whist also assessing treatment needs for the future. If the duration of the therapy episode is fixed (e.g., the client is only seeking immediate and not long term help, or the clinician is employed to only work with people over a brief window of time such as 4 weeks) that needs to be made explicit and discussed together so that the work has an intentional beginning, middle and end within the time available. Being clear from the outset about what the service or clinician can and cannot offer is an essential part of setting the therapeutic frame and managing expectations.

Provide an active here and now focus

The therapist stance is to be active, leaning into the conversations and structuring the interactions. Non-directive counselling is not generally useful as it does not structure the time and risks allowing the client to focus on narrating a history of unhelpful problems from the past and previous treatment failures without leaving time to do new work. This can end up reinforcing helplessness and hopelessness that can heighten emotional dysregulation. It might be helpful in these cases to re-direct attention to the present with statements such as “I can hear you’ve had a lot of challenges in the past, and that is certainly important to discuss, but in the time we have today I’d like us to focus on how you are right now and what is happening to you”. Thus, the stance of the therapist may be on “what are your current concerns and what are things we can decide to do together to help you make the next hour, next day, and next week a better one, than the last week?” By being active, the therapist is also looking to bolster existing strengths and capacities that are keeping the client safe.

The therapist is best placed to balance a focus on the person’s challenges, with discussion of ways to improve choices and tolerate difficult thoughts and emotions. By putting themselves ‘into the shoes’ of the client they can then reflect back to them with compassion, their understanding of the client’s current concerns (“I can certainly see how hard this is for you and how you are trying to make sense of it”).

Considerations if the person is in crisis

It is important to balance assessing the client’s current risk and addressing any suicidal and self-harm behaviours, with setting aside time to consider how to help the person in the here and now to solve their current problems. In developing a Care Plan, consideration can be given to triggers and crisis survival skills. Identifying who is in the person’s support network is often helpful. Activating the person’s support network or looking to bolster it may be indicated as part of developing a Care Plan. If the person has been in crisis, it is also important to develop strong links to available services and to seek out further assessment and support. This ensures the person is not isolated and others are aware of their current situation. It can also be helpful to consider connecting with carers (see ‘Include Carers’ in Section 1).

Initial phases

Early in the brief intervention, it is important to:

- **Engage** – As soon as the referral has been received, contact the person to schedule their first appointment. Try to see them within 72 hours of referral.
- **Provide Information** – Clearly describe the service you can offer. People with personality disorders may be unaware of their treatment options.
- **Remind** – Make a reminder telephone call / text message in the 24 hours leading up to the first scheduled appointment.
- **Be Flexible** – If the person is unable to attend, or does not show for their first appointment, follow-up assertively and offer an alternative time or modality (e.g., virtual options if appropriate).

During the intervention

The following steps are recommended during the consultations:

- **Communicate** – Include an overview of the structure and content of the sessions. Be clear about the number of sessions.
- **Assess** – Conduct a focused, supportive psychosocial assessment and continue to monitor risk.
- **Listen** – Attune to the person's current experience. Discuss practical crisis survival skills that relate to their current experience. Validate their current situation and focus on the here and now, rather than past traumas.
- **Educate** – Provide psychoeducation about personality disorders. Describe experiences that are common to people with a personality disorder.
- **Care Plan** – Develop an individualised Care Plan with the person. This may be done collaboratively with the person and integrate crisis survival skills. Setting goals is recommended. A Care Plan will also help the person to engage with treatment providers and services in the future. See 'Developing a Care Plan' in Section 2.
- **Review** – Refine the Care Plan with the person at each appointment. Review progress prior to finishing working with them and ensure there is an understanding about ways to obtain additional community treatment.
- **Encourage** – Support the person to engage in ongoing treatment if necessary. Inform the person of research outcomes for people with personality disorders. Connect them with the lived experience community to gain insight on the recovery journey. Peers can help to instil hope and provide insight into the value of persistence.

Final phases

Consider the following points when nearing the end of the brief intervention:

- **Refer** – Support the person to understand how to seek additional treatment. Discuss the benefits of treatment and refer the person to a service or health care provider.
- **Inform** – Let the person know about the likely time course and outcome of the referral, including waiting periods or timeframes. Support and encourage the person to utilise their Care Plan and discuss options for seeking additional support.
- **Link** – Connect the person with formal and informal peer support services, and with other support groups or clinical services that are available.
- **Anticipate** – Finishing therapy, even if it is brief, may evoke strong emotions and reactions in people with a personality disorder. People with personality disorder can be sensitive to rejection and anxious about their attachments to others, so it is only natural that ending of treatment might be difficult. Discussing and normalising this explicitly is a good idea, even if the client themself does not bring it up. It is important to discuss such issues early and in an open and honest manner. It can also help to anticipate they might want to avoid these feelings by choosing not to attend the final session.
- **Evaluate** – Therapists and services may develop a system of ongoing review of their outcomes to identify potential areas for improvement in clinical practice.

Medium interventions: Working with people for up to six months

If your therapeutic work with a person extends beyond a month, additional considerations apply. In general, the principles from the above brief intervention section are relevant and may be used to guide the initial sessions of medium or longer term psychotherapy.

Develop a psychotherapy contract

A 'psychotherapy contract' is an agreement by a therapist and client to work together for a specified timeframe to work on mutually agreed goals and tasks. Developing an agreement is recommended. People with personality disorder can be highly anxious about their relationships, sensitive to rejection, and struggle to trust others. Therefore, developing a shared commitment is an important and powerful experience that helps put the treatment on a good footing. In general, 'open ended' therapy with no finish or review date may be avoided in the early stages of a person's recovery, especially when sensitivities about rejection and fluctuating motivation to attend sessions is more likely to be prominent. Research has suggested that people are more likely to prematurely leave (terminate) therapy if it is open-ended.[162] Conversely, they are likely to attend more sessions and have higher commitment when there is an agreed end date.

Therapeutic approach

The first and most important task in individual therapy is to create safety and build rapport. The therapeutic relationship is one of the most important predictors of engagement and treatment outcomes for people with personality disorder.

Key features of an effective therapeutic stance include:

- **Consistency and reliability:** A predictable psychotherapeutic environment reduces anxiety, testing, or early termination. This includes consistent boundaries, such as starting and ending sessions on time, and clear and transparent processes. This helps the person to be able to predict what the space of therapy looks and feels like.

- **Active attention to ruptures:** Difficulties such as withdrawal, anger, and idealisation or devaluation are expected challenges often experienced by people with personality disorder. Addressing ruptures early, with an empathic and respectful tone, offers the person an opportunity to learn how to navigate and repair relational ruptures. This also aids in maintaining engagement and models healthy relational repair. People with personality disorder respect and value when a therapist is honest and brings up problems in the relationship to be discussed and resolved together.

- **Active stance:** The stance of the therapist continues to be active and focused on strengthening the client's current situation whilst also working with them to help make wiser choices and make changes to improve their day to day and week by week functioning.

- **Collaborative goal setting:** Shared formulation and treatment planning support autonomy, agency and choice. The formulation is ongoing, and is an opportunity for the therapist to communicate that they are listening and holding the client's experience in mind. Always check in with the person to see if the formulation is correct, and relevant parts of their history or current presentation are up to date. Ensure also that the therapy considers cultural factors and is sensitive to diversity (see 'Ensure care is culturally responsive and safe' in Section 1).

- **Focus on the here and now:** When working with a person over a number of months the core focus of care usually remains on 'here and now' functioning, including working with the person on their current challenges and issues. This is true of all the evidence-based brand name therapies - it is
  through working in the here and now that the most powerful therapeutic changes occur.

Developing an understanding of relationship conflicts

With a longer time in care together, a deeper understanding of the person's sense of self and their understanding of their current relationships (both to themself and to others) can evolve. The treatment may aim to help the person understand and modify any unhelpful relationship patterns in order to more effectively get their needs met. The analysis of unhelpful relationship patterns proceeds on a number of levels:

- The analysis of individual relationship narratives told in treatment (e.g., a narrative about a relationship breakup).

- The aggregation of relationship narratives told to formulate core relationship themes (e.g., multiple narratives about relationship breakups, abandonment and separation experiences).

- Noticing how aspects of the relationship between the clinician and the client may also reflect the person's habitual relationship themes. Discussing these themes and recognising them in the psychotherapeutic relationship can help to disconfirm and repair them (e.g., concerns about trusting the health service and the clinician to provide help). This addresses previous client experiences of rejection, abuse, neglect and trauma, and the stigma associated with obtaining help.

This work can also begin to help the person integrate the past, present and future and strengthen their sense of self. There is an ongoing opportunity to validate that past experiences have happened, that the person wishes they hadn't happened, but the events are in the past. This may require difficult yet important acceptance of reality regarding the person's history and experience, invoking difficult emotions and grief. Processing these traumas, regrets and painful experiences can take time, but exposure to these thoughts and feelings in the safety of the therapy room can bring forth healing. The goal can also be to modify the person's relationship with their past, so they don't repeat this into the future. Creating emotional distance, diffusion and greater freedom to experience these feelings and thoughts can unlock a person's creativity and curiosity. There can also be an opportunity to focus on physical health challenges and other issues affecting the person's quality of life.

Longer term interventions: Working with people beyond six months

If the care can be extended to longer term work, then there is an opportunity to further broaden the focus of discussions. The same principles as the sections above apply - that the focus is on here and now interactions and relationships. The therapist's stance continues to be active and focused on enabling the client's growing sense of agency and capacity to make wise choices. When interactions can be extended, further reflection can then occur to help the person focus on broader life issues, including their physical health, vocational options, and relationship choices. Longer term and more difficult issues in relationships, especially with important people in their life, can benefit from more sustained focus. In addition, intersecting themes of social, cultural, religious, political and familial perspectives may be a focus of work. In this way, a whole of life perspective can be brought to the discussions that can deepen contact with inner experiences, meaning, connection, and values and beliefs.

Individuals with personality disorders who are flourishing, tend to describe meaningful relationships and social connectivity, satisfaction in their work, fewer or more manageable crises and optimal emotional wellbeing. This emphasises the importance of functional recovery, sense of purpose, and quality of life across all domains. Integrating a whole-person approach into care may better support people with personality disorder by promoting mental and physical health and meaningful productivity toward their work, education, and other life goals.[44, 163, 164] The therapist should be open to notice that with these changes the client may enter remission and show signs of longer term recovery from the disorder. Work with people in this phase continues to strengthen the therapeutic alliance, compassionate listening, respect and ensuring clear pathways for continuation of care across different services.[165]

Section 5

Other modalities of treatment in the community

Group psychotherapy

Group psychotherapy offers unique opportunities for psychological growth and recovery. Within the group, members can receive feedback, explore relational challenges, and experience corrective emotional and interpersonal experiences. The group format provides a live social microcosm where interpersonal patterns can be observed, tested, and revised in real time.

Extensive research supports the efficacy of group-based interventions. Meta-analyses[166, 167] demonstrate that well-structured group therapy can reduce symptoms and improve relational functioning for individuals with personality disorder. Mechanisms of change include interpersonal feedback, social learning, belonging, normalisation of experience, and the provision of psychoeducation in a supportive context.

There are specific manualised brand name group therapy programs developed for people with personality disorder. Examples include Dialectical Behaviour Therapy (DBT), Mentalisation Based Therapy (MBT), Schema Focused Therapy (SFT), and Systems Training of Emotional Predictability and Problem Solving (STEPPS). While these different brand name group therapy programs outline different procedures, effective groups share several core processes in common: 1) they cultivate cohesion; 2) view the group “as-a-whole” rather than a collection of parallel individual sessions; 3) encourage curiosity about one’s own and others’ minds; 4) structure and predictability provide containment; 5) clinicians model curiosity, validation, repair, and flexibility, reinforcing the relational skills that underpin change.

Co-facilitation

Group therapy is most effective when co-facilitated. Having two facilitators allows for shared emotional labour, provides a model of collaboration, and ensures continuity in the event of one facilitators absence. Co-facilitators can undertake complementary roles. As an example, the Primary Facilitator may be a trained mental health clinician responsible for formulation, risk management, and maintaining therapeutic structure. The Secondary Facilitator may monitor group process and emotional tone, or individual distress. This arrangement enhances containment and reduces burnout risk.

Co-facilitation by a peer worker

There is emerging evidence that a clinician and peer worker can make an effective group facilitation team, by working together and sharing different perspectives and expertise.[145] Groups can be co-facilitated by peers and clinicians or by peer workers only, in online or face to face formats.[168] If possible, it is recommended that peer facilitators have a lived experience of personality disorder, as this fosters greater empathy, hope, authenticity and connection among participants.[95, 169] Group facilitators can play a key role in modelling and reinforcing safe storytelling practices,[170] inviting participants to share their experiences in ways that prioritise emotional safety and mutual respect. As with all clinicians, peer facilitators also require clear boundaries around self-disclosure, access to supervision, and debriefing after emotionally intense sessions.

Peer-led and co-facilitated programs can lead to decreased symptom severity, greater emotional regulation, and stronger connection and community. Peer groups provide a sense of mutual safety and belonging, fostering a sense of understanding, empowerment, and agency within the persons recovery. It is desirable for groups to be co-designed by people with lived experience. Examples of co-designed session themes may include addressing internalised and external stigma, developing a compassionate and accepting sense of self, building emotion regulation and creative recovery skills, identifying meaningful interests and activities, wellness planning, and strengthening interpersonal relationships and boundaries.[145, 147, 171]

Project Air Strategy has developed a program for peer workers, mental health professionals and services who are interested in providing co-facilitated programs for individuals with personality disorder. See the Project Air Strategy website (https://www.projectairstrategy.org) for Project Air PEERS.

Collaboration and debriefing

Co-facilitators may hold brief pre-session meetings to review the session plan, discuss member updates, and consider any emerging risks. Post-session debriefs provide an opportunity to reflect on group dynamics, process emotional impact, and plan adjustments. Regular supervision and co-facilitator check ins are important to manage countertransference, maintain consistency, and support ongoing professional development.

Developing shared expectations

Establishing a group agreement during the first session is an important step in creating shared expectations and psychological safety. This process allows participants to identify their individual goals, agree on group boundaries, and discuss approaches to managing challenges or sensitive topics in future sessions.[168] The initial session also provides an opportunity for participants to ask questions, develop rapport, and build trusting relationships within the group. Establishing clear yet compassionate boundaries supports a sense of safety and care within the group. Guidelines may suggest group rules include avoiding detailed discussions of trauma, self-harm, or suicidal experiences; while ensuring participants know they can engage in one-on-one support with facilitators or explore these matters with existing support networks as needed. If a participant begins to feel overwhelmed but feels able to remain in the group, this can provide a meaningful opportunity for the facilitators and group members to model emotion regulation skills.[95, 169]

Facilitation skills

Effective facilitation requires a balance between expertise and openness. The therapist stance combines clinical knowledge and structure with a ‘not-knowing’ attitude, remaining curious, collaborative, and receptive to others’ perspectives. This stance demonstrates flexibility and encourages members to expand their understanding of self and others.

Facilitation involves several overlapping skill domains:

- **Facilitating:** Managing time, encouraging participation, exploring experiences, and modelling curiosity. Facilitators may monitor pacing, decide on breaks as clinically indicated, manage turn-taking, and meet interpersonal challenges with new relational responses that model change.

- **Protecting:** Maintaining boundaries, reinforcing confidentiality, ensuring consistency and predictability, and keeping the group on track within its agreed therapeutic frame.

- **Linking:** Helping members connect theoretical material to lived experiences, drawing attention to here and now interactions that illustrate therapeutic principles.

- **Supervision and Self-Reflection:** Ongoing supervision and reflective practice are important for maintaining balance between expertise and curiosity, and for protecting facilitators' wellbeing.

Managing group dynamics

Group composition and structure may be considered carefully. Optimal group size typically allows for diversity of experience while ensuring each voice can be heard. Pre-treatment processes (such as screening, orientation, and agreement on boundaries) enhance safety and engagement. Group sessions generally last between 60 to 120 minutes, with treatment duration and frequency tailored to the program model.

Facilitators may anticipate and manage common relational challenges including splitting, idealisation and devaluation, boundary testing, withdrawal, and projective identification. These behaviours often reflect underlying attachment patterns rather than deliberate defiance. When ruptures occur, prompt recognition and collaborative repair strengthen cohesion and model healthy relational recovery.

Caring for the group

Psychological safety is foundational. Facilitators may foster predictability, empathy, fairness, and respect, maintaining transparency about process and structure. While attending to individual needs, facilitators may also preserve focus on the group as a collective. Mutual support is encouraged, but members are not to be burdened with responsibility for others' wellbeing. Celebrating moments of progress and connection reinforces group cohesion and resilience. Ruptures or conflicts may be framed as opportunities for learning and growth.

Caring for the facilitators

Working with groups may be challenging. Regular clinical consultation, debriefing, and peer support are vital to maintain perspective and prevent compassion fatigue. Professional boundaries must be consistently upheld, and facilitators may prioritise personal wellbeing through self-care and restorative practices.

Creative therapies

Creative therapies have demonstrated effectiveness in treating people with personality disorder by enhancing interpersonal relationships, strengthening identity, and helping individuals navigate polarised emotional experiences.[146, 172, 173] Creative therapies can be provided individually or in groups. They are an established form of psychotherapy that integrate creative expression within a structured therapeutic framework, utilising modalities such as visual arts, music, writing, drama, movement, clay and sand play.[174]

Creative therapies offer unique therapeutic benefits by providing alternative pathways to access and express emotions that may be difficult to articulate verbally. Creative therapists are specially trained in the therapeutic use of creative modalities, underpinned by psychological theory, to support emotional and mental wellbeing. They are also equipped to respond therapeutically to individuals' creative processes in a safe and supportive manner. Creative therapists generally hold advanced qualifications in their specific modality. Clinicians without formal creative therapy qualifications can incorporate structured creative activities into individual and group work, using the core components of art therapy to support safe and meaningful creative expression. These activities can enhance engagement, self-reflection, and emotional exploration within a supportive environment. However, creative therapists have a specialised scope of practice so clinicians may consider a referral if specific issues arise.

Considerations for personality disorder

Creative therapy can support individuals living with personality disorders in navigating interpersonal relationships.[175] As an example, artwork can serve as a neutral third object between the individual and the clinician, offering a safe and indirect way to foster connection. This mediated form of interaction can provide a helpful buffer for those who find direct interpersonal engagement overwhelming or threatening. Through artmaking, individuals may find it easier to explore vulnerability, build trust, and engage in more meaningful relational experiences.

It is important to recognise that individuals with personality disorders may experience added pressure or anxiety around creating a 'successful' or 'perfect' piece of art. The concept of failure or imperfection can feel especially distressing. If someone does not feel safe or comfortable engaging in traditional forms of artmaking, it is important to provide a variety of materials and approaches that allow for exploration without pressure. Activities such as knitting, colouring, or working with clay can be particularly helpful, as they offer opportunities for repetitive, sensory engagement and soothing movement, without the expectation of producing a finished product.

Lived experience perspectives highlight that art therapy can also serve as a valuable distraction from reality. Rather than exclusively operating as a space for reflection, artmaking may provide a way to symbolise difficult or painful thoughts and feelings in a way that is safe.[172] Individuals with lived experience advocate for a diverse range of therapeutic modalities and adaptations to be accessible for people with personality disorders, emphasising that a person-centred approach may consistently guide the integration of creative activities in treatment.

Principles of Art Therapy

There are several manualised and evaluated art therapy programs developed for people with personality disorder.[147, 174, 176-178] The following principles synthesise some key features of these programs.

Challenging internalised beliefs

Art therapy prioritises the creative process over the final product, focusing on exploration, emotional expression, and personal meaning rather than technical skill or aesthetic value. A key therapeutic task is supporting individuals in unlearning internalised cultural beliefs about what makes art 'good' or 'successful'. In a safe, non-judgemental environment, individuals are encouraged to express themselves freely, embracing their unique creative process without the pressure to perfect a visual outcome.

Encouraging experimentation

Individuals are supported in trying new modes of creative expression, developing a greater tolerance for uncertainty, ambiguity, and imperfection, which may be key areas of growth in the treatment of personality disorders.

Emotional regulation

The act of artmaking is inherently regulating and self-soothing, offering a calming experience through its rhythmic, repetitive, and immersive qualities. Through symbolic distancing and multisensory engagement, artmaking facilitates the safe expression of feelings and promotes the integration of affective states, contributing to overall emotional balance and wellbeing.

Here and now focus

Art therapy engages both body and mind to anchor individuals in the present moment. By incorporating sensory grounding techniques, such as noticing textures, colours, or sounds, it helps reduce dissociation and enhance mindfulness. This embodied focus supports emotional regulation and encourages meaningful self-expression.

Working with trauma

Some traumatic memories may be encoded through visual imagery and bodily sensation. Therefore creative therapies may be ideally suited for working with early developmental trauma due to its non-verbal approach.[175] Art making uses both imagination and focus. This helps build new brain pathways and facilitates the processing of emotions. Even after trauma or stress, the brain can learn and heal.[179] Art uses sights, sounds, and movement to support this change. Creative work in groups can facilitate mirroring of feelings and understanding. Art therapy may benefit individuals by improving brain activity and neural integration across various domains, enhancing regulation of stress hormones and reducing perception of pain.[180]

Peer work based on lived experience

People with personality disorder can benefit from the peer work care provided by a person with lived experience.[181-183] Peer workers can contribute effective, compassionate, and recovery orientated care that is a unique and important role within a mental health service.

People with personality disorders may be isolated and may have experienced stigma from others including health care workers. Meeting and talking with a person who has experience of the disorder and has been on the recovery journey can be a powerful experience.[95, 171] Peer workers can use their lived and living experiences to build trust, provide support, connection, understanding and hope.

Studies have shown that peer work can lead to greater engagement in care, improved self-care, lower rates of hospital readmissions, less critical incidents, better health outcomes, greater hope for recovery, increased understanding of recovery oriented care, cost benefits to the health system, improved staff culture, retention and wellbeing.[181] In addition to individual sessions, there is growing evidence of the benefits of groups that are facilitated by peer workers supporting people diagnosed with personality disorders.[145, 147, 171, 181, 184]

Carer Peer Workers

Carers have described that support from carer peer workers helped them feel understood, heard, validated and comforted.[171] Carer peer workers draw on their own lived experiences of supporting a loved one, family member or friend with mental ill health, providing mutual understanding, emotional and practical support, helpful strategies and resources, and individual advocacy.[95, 171, 185, 186] Carers supported in this way report greater resilience and a strengthened sense of understanding and empathy for those with personality disorders.[95, 171, 185] Preferably carer peer workers would also have experience caring for someone with a personality disorder as this may enhance relatability, trust, and the capacity to provide meaningful hope-based support.

Virtual psychotherapy

People with personality disorder may experience challenges in attending face to face sessions in a clinic, making alternative modalities an important option for care.[187] Virtual psychotherapy broadly refers to mental health treatments that are delivered through digital platforms. This may include voice or video calls, telehealth, or options such as mobile applications, messaging or chat services. Blended care refers to a hybrid approach where traditional face to face therapy is combined with online elements (such as some virtual sessions, or the inclusion of virtual tools). Virtual modalities of care can be utilised for individual and group psychotherapy, ranging from brief therapies, crisis assessments and interventions, creative therapies, peer work sessions and longer term treatments. There are published recommendations for conducting virtual psychotherapy for people with personality disorder.[187] The following summarises some of the key considerations.

Establishing the frame

Virtual psychotherapy requires additional considerations to establish a clear and successful frame. Prior to commencing, an initial phone call can assist in orienting the client to the expectations of virtual engagement. This includes assessing whether clients have access to the required technology, stable internet connection, and a private and quiet space.

Clinicians may benefit from orienting clients to establish their own virtual therapy ritual to prepare their space and mind prior to the session. Guidance in setting up the virtual therapeutic space may include 1) thinking about goals for the session 2) wearing appropriate attire 3) sitting in a chair 4) using a static video-camera 5) ensuring clarity of lighting and sound 6) using earphones with a microphone 7) having water and tissues available if needed 8) minimising distractions from other people, pets and technology (e.g., closing any applications that are open to prevent alerts, having an uncluttered environment and door closed).

In addition, it is important to emphasise that virtual psychotherapy follows the same procedures as face to face engagement, dispelling any preconceptions that virtual sessions are a check in or casual supportive interaction.

Additional reminders and timely assertive follow up of missed appointments can also facilitate attendance. Engaging parents or carers may assist clients in remembering their appointment, setting up for their session and troubleshooting any connectivity issues.

Enhancing safety

Ensuring a safe virtual psychotherapeutic environment requires thoughtful consideration. It can be useful to have discussions with the client and their carer about the assessment and management of risk at the start of each session, including the steps that will be taken if there is any concern. This includes if the client drops out or becomes uncontactable. The clinician may consider what supports are available to assist them should risk escalate. This may include text messaging a colleague to call for an ambulance for your client whilst you remain on the phone or on the virtual platform of care. Other considerations may include direct access to senior colleagues and other multidisciplinary team supports if a situation requires consultation.

Some virtual risk assessments may benefit from the collaborative input from parents or carers on any changes in behaviour, increased concern and clarification of safety plans. Chronic risk may be managed by asking for a parent or carer to be present in the home or available by phone at the time of the appointment. If the client is a young person, or where the client consents, some services may use text messages with carers to manage chronic risk. For instance, messaging the carer when the session has finished, and providing a telephone update at an agreed upon time after they have been able to check in with the client can be helpful. This includes providing feedback to the carer regarding any risks, and any updates on the safety plan

Virtual psychotherapeutic safety is also enhanced by strong leadership support, clear governance structures, training and resources.

The virtual psychotherapeutic alliance

The alliance is established on a foundation of shared goals and tasks, and the bond between the clinician and client. Developing a strong psychotherapeutic alliance can be more challenging when using virtual modalities. Clinicians may need to consider how to ‘hold’ clients in the virtual psychotherapeutic space by creating a sense of safety and compassionate support. This may include consideration to their use of voice, pace, visible body language and expression, and virtual eye contact to clearly portray empathy and understanding. Clinicians may wish to alternate between looking at the client’s image on-screen to looking directly at the camera whilst talking. This may assist to balance between the need to observe the client’s facial expression and body language, with providing eye contact through the camera. The clinician may need to be mindful of the increased possibility of misunderstandings and invalidation, particularly when facial features, body posture or vocal tone is masked. Therapeutic discussion may need to be intentionally dyadic. This may include encouraging frequent turn taking to ensure a mutual balance and engagement of client and clinician in the work.

Asking clients to type their session goals into the chat function at the start of the session can increase engagement, sense of agency and client-ownership of the session. The clinician might also add some ideas, which together may form the agenda that can be referred to throughout the session. It might help to utilise the opportunity to practice experiential exercises or use engaging resources, such as sharing screen for videos emphasising key points or skills.

Section 6

Working with specific groups and settings

Young people

Diagnose and respond early

Most people diagnosed with personality disorder remark that their problems first began when they were young in their school years (late pre-adolescence or during adolescence).[32, 188] Adolescence is a vulnerable phase for many young people with numerous social, biological and physical changes taking place simultaneously. There has been a historical misconception that personality disorders cannot be diagnosed prior to the age of 18, on the incorrect view that since personality is being developed it cannot also be disordered. However, mental health problems are best addressed early or they are likely to persist and interfere with healthy development.[189] The consequences of not identifying and treating emerging personality disorder can be severe and enduring.[190-192] Research shows many adult clients with the disorder experienced a delay in diagnosis, estimated to be an average of 18.1 years[32] and many feel they would have benefited from diagnosis and treatment during their adolescence.[32, 192] Young people under the age of 18 years can be diagnosed with a personality disorder.[22, 192, 193]

Clinical assessments help to formulate a young person's needs and can include an evaluation of self-functioning (identity, self-direction), interpersonal functioning (empathy, intimacy) and chronic and acute risk factors. Clinicians should remain mindful of the developmental changes occurring during adolescence and carefully differentiate between 'typical' and maladaptive behaviours. These distinctions can be made based on the severity, duration and frequency of unhelpful behaviours.[194] Specifically, difficulties persisting over a year should not be dismissed as a transient phenomenon.[195]

Recognise common comorbidities

Clinicians may be aware of common comorbidities to inform differential diagnoses. For example, people with a personality disorder are three times more likely to have a mood disorder (e.g., depression), twice as likely to experience anxiety disorders, three times as likely to develop substance-related issues, and are at significantly increased risk of developing an eating disorder.[196] Importantly, these associations were found to be especially strong in childhood.[196]

Although trauma is common among individuals with personality disorders, it is not universal.[2, 190] Research suggests BPD and PTSD co-occur in approximately one-third of young people.[197]

Attention deficit hyperactivity disorder (ADHD) may also be considered. Research has found that 13.5% of children with ADHD were later diagnosed with BPD in adolescence.[198] Further research has found between 33%[199] and 38%[200] of people with a diagnosis of BPD met criteria for ADHD. In addition, autism spectrum disorder (ASD) may be considered, although currently it appears they co-occur at rates no different from the general population prevalence of between 3-4%.[201]

Early psychotherapeutic intervention

Psychotherapy is the treatment of choice for personality disorder and has been shown to be effective in young people.[192, 202] Early treatment can reduce the risk of ongoing challenges into adulthood.[192, 203] Personality disorder traits in adolescents are considerably more flexible than in adulthood, highlighting an important opportunity to offer early intervention which can be relatively short term - usually less than 6 months.[204, 205] Clinicians may remain cognisant of emerging personality traits191 and consider the benefit of intervention even in the absence of a formal diagnosis. Importantly, a lack of formal recognition of emerging symptoms that do not meet full diagnostic criteria has been identified as one barrier to young people accessing appropriate intervention.[206] Young people tend to move in and out of treatment, so flexibility and responsiveness is important.

There are several manualised brand name interventions that could be considered, including Dialectical Behavioural Therapy for Adolescents (DBT-A), Mentalisation-based therapy for adolescents (MBT-A) and Cognitive-Analytic Therapy (CAT). Although more research is needed, there is no evidence of superiority of any brand name approach, and the quality of the clinician and shared common factors between therapies are likely to be responsible for the majority of therapeutic efficacy. General psychotherapy principles, and generic approaches developed for young people with personality disorder, are likely to be effective and may be used. Project Air Strategy has published several guidelines for psychotherapy with young people with personality disorder.[207-209] Whole of school approaches that consider ways for schools to respond compassionately to young people are also available.[38]

Ideally, young people may receive help in youth-oriented services where possible. Where this is not possible, clinicians may remain mindful of the unique needs of young people. Treatment may follow the same general fundamentals and principles described in this guide, including being relationally focussed. It is recommended for the therapy to be individualised, based on severity and developmental stage, and address personal and interpersonal difficulties.

Include family, parents, or carers

Where possible, it is helpful to include families, recognising their role as allies in recovery. Families, parents, partners and carers of young people with personality disorder can experience significant distress within this role.[30, 31, 210] Family and carer involvement can help when working with young people with personality disorders.[211, 212] Preliminary research suggests family-inclusive approaches may improve family relationships, improve carer empowerment and mental health, and decrease levels of burden.[37, 97, 211, 212]

In general, it is recommended to provide families and carers with psychoeducation about personality disorder, including challenges in emotions, communication and risk, and how to respond in a helpful way. It may also help if families are able to be part of care planning, to allow good collaboration and understanding of the goals, triggers, skills, strategies and supports. Carers who are parents may experience additional challenges, such as emotional, physical, financial and relationship strain. Parents may also feel particularly sensitive to perceived blame for their young person’s difficulties. It can be helpful to support parents to identify a unified approach to crisis management, boundary setting, and consequences of behaviours, ensuring that they are both able and willing to be consistent with this plan.

It is also important to consider when a young person does not want their family involved.[213] While family involvement is often beneficial in the treatment of personality disorders, clinicians must also respect the autonomy and legal rights of young people, particularly those aged 14 and over who may be deemed capable of making informed decisions about their care.[214]

Responding to risk of harm to the young person

Clinicians working with young people must remain vigilant about their legal and ethical responsibilities. While therapeutic relationships are built on trust and confidentiality, these obligations override privacy when there is a reasonable suspicion of harm, abuse, or neglect. This is particularly important in the context of personality disorders, where interpersonal sensitivity may be heightened. Clinicians should approach these situations with compassion, clarity, and professionalism, ensuring that the young person feels supported even when difficult decisions must be made. Young people should be involved in decision making wherever possible.

Assessment and management of self-harm or suicidal risk in young people

The assessment of risk in young people who engage in suicidal and non-suicidal self-harming behaviour can be complex. Assessment of intent to die is often complicated in young people as they sometimes report their intent changes (e.g., “I started off wanting to die, but realised I didn’t halfway through”), or is less clear than expected (e.g., “I don’t really know if I wanted to die or not”). In addition, young people may have a poor understanding of the lethality of the means they are using to self-harm and consequently might be at high risk of a serious accidental outcome. Conversely, some young people have researched suicide extensively online. Clinicians are advised to complete a thorough assessment of these factors.

Because of their age, clinicians can find themselves doing more to help the young person than they usually would. Similarly, young people can present as more helpless or extreme in their emotional expression, which can make it difficult for clinicians to provide a consistent response. It is crucial for clinicians to recognise these reactions and seek support through clinical consultation.

My Care Plan

Name: Clinician Name*:

My main therapeutic goals and problems I am working on

(1) In the short term

(2) In the long term

My strategies

Warning signs that trigger me to feel unsafe, distressed or in crisis

Things I can do when I feel unsafe, distressed or in crisis that won't harm me

Things I have tried before that did not work or made the situation worse

Places and people I can contact in a crisis:

Lifeline: 13 11 14 **Emergency: 000** **Kids Helpline: 1800 551 800** **Mental Health Line: 1800 011 511**

Local Service:

My support people *(e.g. parents, siblings, friends, psychologist, teacher, school counsellor, GP, relatives)*

Name	Contact Details	Role in My Care	OK to Contact?

Signature: Clinician's Signature:

Date: Date of next review:

Copies must go to the people that can help to keep me safe. These people are (please specify):

***Write and/or review in partnership with young person and a health care professional, for example School Counsellor/School Psychologist, CAMHS clinician or GP.**

Working with young people in a hospital setting

Young people engaging in self-harm and suicidal behaviours have rarely established a recurrent pattern of harming themselves warranting admission to inpatient wards. Even when this pattern appears to be emerging, there is an important opportunity to intervene and help the young person establish more appropriate ways of accessing care and support. This may include developing a youth specific My Care Plan. It is important to remember that many unhelpful and frustrating patterns of behaviour might inadvertently be reinforced by the reactions of clinicians. For example, telling a person their behaviour is not severe enough to be admitted to the inpatient unit may increase self-harming behaviours to gain hospital admission.

Children and young people in Out of Home Care

Out of home care (OOHC) occurs when a young person is removed from their family due to concerns about safety, abuse or neglect. Young people who have been removed from their family may have considerable trauma. They are more likely to have disrupted schooling, poor academic achievement, later homelessness and poor mental health.[215, 216] Children and young people who have experienced child maltreatment are at increased risk of engaging in suicidal behaviours and it is recommended clinicians routinely screen for suicidality.[217] Although there is limited research, it is possible that these experiences may exacerbate or trigger personality disorder symptoms. In these cases, it is recommended to use assessment frameworks that consider the developmental impact of chronic trauma, especially emotional abuse and neglect[218] and bodily intrusive maltreatment.[219] It can help to avoid pathologising adaptive survival behaviours (such as aggression, withdrawal or emotional dysregulation), and instead frame these within the context of disrupted attachment and chronic adversity. This acknowledges that young people are developing skills to cope with challenges and are doing their best.[220, 221] Relational and attachment-based interventions are likely to be indicated for youth with these difficulties.[222]

Parents with personality disorder

People with personality disorder may also have their own children. Managing a personality disorder and the stresses of parenting at the same time can be challenging.[223] Symptoms of a personality disorder can include difficulties in affect, identity and relationships. This can impact on the person's capacity to relate to others, including children, in a consistent way.[224]

Project Air Strategy has developed and evaluated a parenting with personality disorder program offered in individual or group settings.[148, 225-227] The goal is to support parents, children and families to enhance protective factors and to identify and reduce risk factors. The program specifies three main targets of focus, as described below.

Engage the parent and reinforce safety for all

Establishing a good therapeutic alliance with the person forms the basis for the rest of the work. It is important to explain to the person with personality disorder that discussing parenting can be relevant and helpful, addressing any fears or reluctance. It may be useful at this stage to introduce a discussion of the person's goals as a parent. Collaboratively completing a Family Crisis Care Plan can be beneficial, which specifies how the family will respond if the parent becomes unwell (e.g., needs to go to hospital). This prioritises the care of children and ensures there is a safe plan to manage family crises.

Improve communication and relationships

It may be useful to provide psychoeducation to the person about parent-child attachment bonds and how these can be strengthened. This might include a reflection on patterns of parenting from the past (i.e., as experienced by the person with their own parents). It can then be helpful to reflect on current patterns and how the child's expectations and feelings can be understood, focusing on specific here and now interactions. Ways to strengthen the parent-child bond can therefore be fruitful areas to consider. Holding the child's mind in mind is a specific skill that can be difficult, with the aim for 'good enough' parenting that assists the person to step back, observe and reflect on the child. Working with the parent on ways to play with children can be useful, especially if it provides the opportunity for being close. However, it is important to highlight the benefits of allowing the child to take the lead with the parent reflecting and commenting on the sequences of the play. This can be reinforcing for both the child and the parent, and can strengthen attachment security.

Work to separate parenting from personality disorder

It can help to consider ways to ensure children are shielded from the impact of the mental health challenges of the parent. This can involve the parent with personality disorder ensuring that the challenges they are facing with their mental health are focused on in treatment, and kept in 'adult to adult' settings. This will help the child to relate to the person as their parent, with a focus on the child's needs. Talking to children about the parent's mental health challenges can help them understand these difficulties, without blaming themselves. Working with the person to identify limits that need to be set within the home can help reinforce safety and security, and prevents the child being drawn into a parenting role.

Key principles for working with people with personality disorders who are also parents

- Prioritise child safety and encourage parents to do the same.
- Listen to parenting struggles in a non-judgemental and accepting manner.
- Focus on building trust and rapport, as parents with mental illness can feel vulnerable.
- Recognise and value parents' strengths and positive attributes.
- Re-affirm that the goal is to be a 'good enough' parent, not perfect.
- Help the parent to keep their child's needs and feelings in mind despite mental illness sometimes getting in the way.
- Help parents to facilitate open discussion with their child about what is happening in the home, including discussing the parent's mental health issues and their diagnosis.
- Ensure a Family Crisis Care Plan is in place for when the parent is very unwell.
- Help parents with parenting skills, including age-appropriate ways of relating to their child and setting firm yet kind limits to protect everyone.
- Where possible seek opportunities to protect children from being distressed by mental illness.

See the Project Air Strategy website (https://www.projectairstrategy.org) for Manuals, the Family Crisis Care Plan, Fact Sheets and Videos relevant to parenting with personality disorder. This program also gives information for supporting children involved.

Supporting children who have a parent with personality disorder

Children who have a parent with personality disorder may require additional support. At times, children may blame themselves for their parents challenges or assume a caregiving role. Young people's childhood needs to be protected, including supporting their engagement in activities and opportunities that are developmentally appropriate (for instance, schooling, sport, music or other interests) similar to their peers. Clinicians may support young people by assessing and monitoring any risk, offering treatment for emotional, behavioural or mental health concerns, and ensuring a school support system is in place. Supporting young people to clarify their role in the family, including relinquishing caregiving or parentified roles, can be helpful. Clinicians may also refer young people to appropriate or specialist services for additional support such as group or community programs to reduce feelings of isolation and burden.

Family Crisis Care Plan

This plan can be used in the case that children's legal guardian is unable to care for them temporarily due to mental illness or hospitalisation. It represents the intentions of the legal guardian at the time of creation, however, is not a legally binding document. Ideally, all legal guardians will be aware of, and in agreement with, this plan.

Parent Name: **Children's Names:**

If I am temporarily unavailable to care for my children, I would like them to stay with one of the following consenting adults:

Name:_____ Name: _____

Relationship to children:_____ Relationship to children:_____

Contact Number:_____ Contact Number:_____

Address:_____ Address:_____

I would like to exclude the following people from visiting or caring for my children:

Name:_____ Name:_____

Relationship to children:_____ Relationship to children:_____

Are there any current court orders in place regarding care or visitation of your children? Please attach or provide details:

Important information about my children:

My children's daily routine (daycare, school, activities, food, bedtime, etc.):

Things that help settle my children when upset (likes, dislikes, favourite toys or books, etc.):

My children's health or medical needs:

I would like to keep in touch with my children via:

Contact details for key people (school, doctor, etc.):

Signature: **Clinician's Signature:**

Date: **Date of next review:**

Copy for the: Client / Clinician / Temporary Carers / Children / Emergency / GP / School / Case Worker / Other (please specify)

Older adults

Personality disorder may involve a dynamic lifelong vulnerability, with the expression of difficulties depending on contextual and developmental factors from childhood to older adulthood.[228, 229] Older adulthood (referred to here as 60+ years of age) can be a period when personality difficulties first appear to emerge. Some older adults may meet criteria for a diagnosis of late-onset personality disorder. Major life events can trigger personality difficulties, such as death of a spouse or partner, the ending of a meaningful career, or transition to a nursing home or assisted-living facility.[228] Sometimes the delayed identification of personality disorder can be related to the loss of social supports that had previously protected the person from experiencing the full expression of pre-existing personality vulnerabilities.[228-230] Alternatively, this may be the first time the person has needed to engage with the health service due to deteriorating physical or cognitive health, and has otherwise successfully lived with undiagnosed personality disorder.

Age differences in symptom expression

The prevalence of personality disorder in older adults varies between 8.1%-14.5% in the general population, between 24.1%-60.0% in treatment-seeking populations, and between 22.5%-57.8% in nursing home facilities.[231, 232] Personality disorder in older people, especially those in residential care, can be one component of a complex number of difficulties that cascade with ageing. There is evidence to suggest that typical ways of assessing personality disorder are not fit-for-purpose for older adults[233-236] and can form a barrier for accurate and timely diagnosis in this population.

Compared to younger people, a personality disorder in older adults is associated with lower quality of life, more somatic and psychological problems, and lower adaptation to age-related changes such as loss of loved ones, physical decline, and reduced independence.[237, 238] Personality disorder in older adults may also be complicated with other age-related comorbidities, such as dementia or cognitive decline.

Rates of death by suicide are highest among adults aged 60 years and older in most countries.[239] Older adults have higher levels of physical frailty[240] and tend to use more violent and lethal suicidal methods,[241] resulting in a higher risk of dying on a first suicide attempt in comparison to younger people.[242] Self-harm is one of the strongest predictors of death by suicide for older adults.[243, 244] Reasons for older adults to engage in self-harm can be diverse, such as seeking relief from overwhelming emotions, communicating a need for understanding, support, or help from others, or evoking sympathy.[245, 246] Examples of self-harm in older adults can include indirect methods such as substance abuse, refusal to eat leading to starvation, medication refusal, and self-neglect, or direct methods such as cutting or scratching.[231, 232]

Some key differences between how personality challenges may be exhibited in young adults when compared to older adults are provided below.

Affect: The same difficulties with emotion regulation that young people experience tend to remain in older adulthood. However, emotion dysregulation may be expressed in a more depressive, somatic, or passive-aggressive way in older people[247, 248] and they are more likely to suffer from co-occurring depression.[249, 250] Behaviours associated with impulsivity in younger adults (e.g., acting out, risk-taking, and substance abuse) are often not major features of personality difficulties in older adulthood[247, 248, 251] although they are more likely to suffer from co-occurring depression.[249, 250]

Identity: The kind of identity disturbance seen in younger adults with personality challenges is thought to dissipate with older age.[251, 252] However, there is some evidence to suggest that the difficulties manifest differently, expressed instead as regrets about life choices concerning spouse, career, values and parenthood.[253]

Relationship: Older adults with personality disorder may experience significant social isolation. Themes of idealisation and devaluation in relationships can persist in older adults with personality challenges, including those with health care providers.[253] Older adults with these challenges can exhibit somatisation, often expressed in dramatic and frequent demands for medical attention.[254, 255] They may also present as demeaning, passive-aggressive, or overtly hostile in an attempt to have their complex needs met.

Assessment

The identification of personality disorder in older people may need to rely on a combination of clinical interview and informant reports. Informant reports can provide valuable insights into the older adult's personality, psychosocial functioning, and may be useful in verifying life events. Informants may also assist in overcoming the potential effects of age-related sensory and cognitive impairment.[232] Short screening questionnaires may be helpful depending on the capacities of the individual using measures designed for older adults.[233, 235, 236, 256] There are now a number of brief age-neutral measures of assessing personality disorder in older adults.[232, 257, 258]

Psychotherapy

Studies into psychotherapy for personality disorder have mainly included adults between the ages of 25 and 40,[259, 260] however it is likely that these procedures will be helpful for older adults. For example, some studies support the feasibility of Dialectical Behaviour Therapy (DBT) and Schema Therapy for older adults.[230, 261-263] Psychological interventions for older adults with personality challenges can be considered on a spectrum, from: 1) supportive-structuring approaches (e.g., psychoeducation, behavioural support), 2) adaptation-focused approaches (e.g., social skills training), 3) personality-changing interventions (specialised psychotherapy).[232, 264, 265] Broadly, interventions may focus on targeting underlying impairments, such as low mood, and improving social functioning.[228, 266, 267] Many older adults with personality disorder may present as very isolated with few social supports, and so bolstering social connections and engagement with community based support-services may also be a focus of care. It may be relevant when assessing the style of therapy to consider functional limitations associated with any somatic and cognitive comorbidities.[232, 264, 265]

Forensic settings

People with personality disorder are highly prevalent in forensic settings. A systematic review of 62 studies across 12 countries found 65% of men and 42% of women in custody had a personality disorder.[268] Research has shown that in custodial settings people with a personality disorder diagnosis have higher rates of self-harm than those without personality disorders.[269-271] In custodial settings, it is recommended to implement least restrictive care during crisis or self-harm. It can be beneficial to collaboratively complete a Care Plan that is tailored to the opportunities and restrictions of the custodial setting. With the person's consent, this may then be shared across disciplines to enhance a supportive approach to care.

It is recommended that clinicians working in custodial settings are offered additional training in cultural competence and trauma-informed care principles.[272] Many individuals in forensic settings have experienced significant trauma throughout their lives. A trauma-informed approach promotes safety, trust, and empowerment, and is particularly important in forensic contexts where trauma exposure is common.[273] In addition, custodial settings may be challenging,[274] as traumatic and abusive experiences amongst prisoners are common.[275] Research suggests 75% of male prisoners are exposed to traumatic events whilst incarcerated.[276] In addition, the rate of imprisonment of Aboriginal and Torres Strait Islander people is between 10 and 12.5 times greater than the non-Aboriginal and Torres Strait Islander imprisonment rate.[277] In order for clinicians to provide culturally responsive care, it is important to engage in ongoing education and awareness of the continued devastating impact of colonisation and intergenerational trauma which have sustained disadvantage towards First Nations peoples. However, it is also important to take a strengths-based approach when working with Aboriginal and Torres Strait Islander people.

Individual psychotherapy is the treatment of choice, although in some situations it may be productive to utilise structured group therapies. There are several published studies on different manualised approaches, including Mentalisation-Based Therapy, especially the version developed for antisocial personality features[278] and Dialectical Behaviour Therapy.[279, 280] Interventions should be tailored to the specific needs of the clients and the service, including secure versus community settings.[281] As an example, it may be particularly indicated to use a here and now focus in secure custodial settings where it may be best for clients not to become emotionally vulnerable during psychotherapeutic engagement, as this can leave clients particularly vulnerable in a high-stress and interpersonally complex environment where other inmates may take advantage.

Working with individuals with personality disorders can evoke strong emotional reactions in staff, including frustration and helplessness.[26, 101] Staff are likely to struggle with their experience of clients as 'good' versus 'bad', and perceptions about who can be treated and helped.[101] This may be particularly heightened in a forensic setting when staff are also cognisant of the conviction and criminological risks and needs of the individual. A consistent, team-based approach supported by regular supervision and reflective practice helps manage countertransference and maintain therapeutic boundaries. Multidisciplinary input is important in challenging people to think in different ways and maximise the benefits from interventions and risk assessment.[272] Interdisciplinary collaboration across mental health, justice, child protection, education and correctional services may ensure continuity of care and reduce fragmentation.[282]

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