An Integrative Relational Step-Down Model of Care: The Project Air Strategy for Personality Disorders

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Abstract

Personality disorders, particularly borderline disorders, represent a significant treatment challenge for mental health services, in part because of the severity of the disorder, but also because of the high prevalence. Approximately one quarter of emergency mental health presentations and inpatient admissions are people with personality disorders. Evidence-based treatment for Borderline Personality Disorder is psychological therapy based on clinical guidelines, yet the prevalence of the disorder presents a challenge to specialist intervention programs that typically are unable to meet the high clinical demand. Similarly, the particular nature of the disorder can challenge the capacity of teams to maintain compassion towards clients, given the particular features of the disorder that can induce negative countertransference responses. An integrative step-down whole of service approach, based on a relational model, is described; this focuses on both the intrapsychic difficulties of the individual and broader interpersonal conflicts that can challenge treatment teams, families and carers, and the broader community. The model includes the whole system supporting the client in the strategy. The Project Air Strategy for Personality Disorders outlines approaches to clinical leadership and service re-design, targeted training, the provision of brief and longer term treatments, rapid access to psychological assistance, support for families and carers, and better access to information and clinical resources to provide a more hopeful and integrated treatment.

Globally, the treatment of personality disorders, particularly Borderline Personality Disorder (BPD), in mental health services is under significant pressure due to their high prevalence and the cost and burden of treatment. People with personality disorders present in significant numbers to Emergency Departments as well as to Mental Health and Drug and Alcohol services. An analysis of data from one large mental health service that are reasonably representative of the State of New South Wales (NSW), Australia, demonstrates that 26% of emergency presentations and 25% of inpatient admissions to mental health beds were for patients classified, using ICD-10, as having personality disorders and related conditions, as shown in Figure 1.

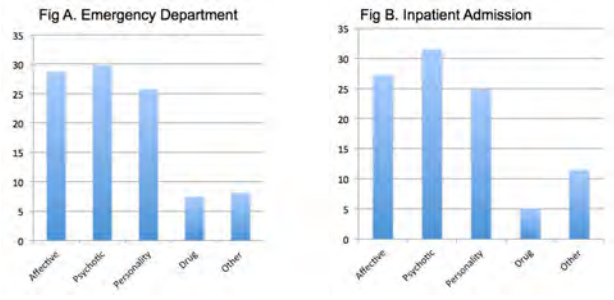

Figure 1. Percentage of all mental health emergency department presentations (Fig A) and inpatient admissions (Fig B) based on ICD-10 classification of diseases coding (affective disorders, psychotic disorders, personality disorders, drug and substance use disorders, and other disorders). Data are for four years from Nov 2008–Nov 2012, Illawarra Shoalhaven Local Health District (total sample N = 6338).

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Generally, 'treatment as usual' involves health services providing crisis management that may include short-term admission for safety and de-escalation of distress. Longer-term service involvement has traditionally been regarded as counterproductive due to mental health clinicians' concerns about reinforcing helplessness and escalating help-seeking behaviour through actions (e.g., increased self-harm). This has resulted, in some cases, in a stigmatised response from mental health services and unconscious negative responses (countertransference) from health professionals. Prevalence data for the disorder vary between countries and based on method. The best prevalence data in Australia suggest that 6.5% of the Australian population has a personality disorder (Jackson & Burgess, 2000), whilst North American data report a median prevalence rate of 10.56% (Lenzenweger, 2008). Further, an estimated 40–50% of psychiatric patients have a comorbid or primary personality disorder, including an estimated 22% of psychiatric outpatients who specifically meet the criteria for BPD (Korzekwa, Dell, Links, Thabane, & Webb, 2008). Similarly, 31.4% of patients with a general mental health disorder (such as anxiety or depression) have been found to also be diagnosed with a personality disorder (Zimmerman, Rothschild, & Chelminski, 2005). The prevalence of personality disorders is the same in both men and women, although their pattern of presentation to services can vary.

The Burden of Providing Appropriate Services

Along with the high prevalence is the high severity of problems, which put considerable strain on mental health services. People with a personality disorder are at increased risk of suicide and self-harm, and frequently have contact with, and pose difficult management issues for, a number of agencies, including Health, Police, Corrections, and Housing. This client group have not always had consistent or helpful responses from the health service and other agencies; hence, there have been difficulties in providing the best

treatment responses, and with clients accepting these when offered. Health service inconsistencies have in some cases led to greater escalation in help seeking and a greater ambivalence towards help provided.

These difficulties extend beyond just mental health and also involve justice, health and corrections. People in correctional settings have higher rates of personality disorder than people in the general community; 43.1% of adult prisoners in NSW reception centres meet criteria for a personality disorder, compared with 9.2% of a community sample (Butler et al., 2006). The presence of personality disorder symptoms in adolescents has also been linked to violent offending and rate of recidivism during adolescence and early adulthood (Johnson et al., 2000; Steiner, Cauffman & Duxbury, 1999). Due to the well-established relationship between personality disorder and violent offending, a diagnosed personality disorder is considered a risk factor in a number of tools used to assess risk of violence (e.g., HCR-20). Offending is often related to symptoms of personality disorder, such as impulsivity, emotion dysregulation, and associated substance abuse. Notably, risk of re-offending among those with a mental illness, including a personality disorder, is increased significantly when a comorbid substance abuse disorder is present (Davison & Janca, 2012; Smith & Trimboli, 2010). By treating personality disorders in the broader community, we will likely reduce criminal offending associated with the disorder in two ways: (1) by lowering the incidence of substance abuse among people with personality disorder, and (2) by helping people with personality disorder re-integrate into society from prison and abstain from criminal offending.

People with personality disorders who seek treatment (e.g., present to Emergency Departments, require outpatient and inpatient care) pose a high economic burden on society, a burden substantially higher than that found for other mental illnesses such as depression and generalised anxiety. A study conducted in the Netherlands (N = 1740) found that the direct medical costs per patient with a personality disorder were AUD$10,760 (€7,398) per year (Soeteman, Roijen, Verheul, & Busschback, 2008), while the indirect cost per patient with a personality disorder and a paying job was an additional AUD$10,309 (€7,088) per year. The total days lost because of absence from work or inefficiency at work was found to be 47.6 per patient per year. BPD was associated with increased direct and indirect costs. According to the Australian National Survey of Mental Health and Well-Being, 4.8% of the Australian full-time workforce has a personality disorder, with a personality disorder being predictive of work impairment (Lim, Sanderson, & Andrews, 2000). A current mental illness was associated with an average of one lost day from work, and three days of reduced performance in the month prior to the survey. Lost work productivity due to mental disorders, such as personality disorders and substance-related disorders, contributes a loss of AUD$2.7 billion each year.

The high societal costs of personality disorders suggest the importance of prioritising the development and implementation of effective personality disorder treatments. Research undertaken in Australia has established a significant cost benefit of implementing appropriate psychosocial treatments for people with BPD (Stevenson & Meares, 1999). One year of psychotherapy was associated with an average decrease in inpatient costs of AUD$21,431 per patient with BPD. Findings suggest a suitable psychotherapy treatment course for BPD will save health services at least AUD$8,000 per patient a year following therapy.

What Is Evidence-Based Practice for BPD?

Clinical guidelines and systematic reviews based on over 25 randomised controlled trials support structured psychological therapy as the treatment of choice for BPD (Grenyer, 2013; Leichsenring, Leibing, Kruse, New, & Leweke, 2011). Recently, the National Health and Medical Research Council (NHMRC; 2012) issued clinical guidelines for the treatment of personality disorders, with some core recommendations in Table 1.

Table 1

Selected key recommendations from the Clinical practice guidelines for the management of borderline personality disorder (NHMRC, 2012).

1. BPD is legitimate diagnosis for healthcare service.
2. Structured psychological therapies should be provided.
3. Medicines should not be used as primary therapy.
4. Treatment should occur mostly in the community.
5. Adolescents should get structured psychological therapies.
6. Consumers should be offered a choice of psychological therapies.
7. Families and carers should be offered support.
8. Young people with emerging symptoms should be assessed for possible BPD.

Of the structured psychotherapies, there is evidence from controlled trials for a number of approaches, including cognitive-behavioural (such as dialectical behaviour therapy and schema focussed therapy), and dynamic interpersonal therapies (such as mentalisation-based therapy, transference-focused psychotherapy, cognitive analytic therapy, and general psychiatric therapy). Because there are few or no differences in efficacy among the different treatments evaluated (Leichsenring et al., 2011), clinical guidelines and researchers have proposed core components of therapy shared by all approaches as the essential ingredients of structured psychological therapy. These include: (1) a focus on the treatment relationship; (2) an active therapist stance towards the client; (3) specific attention on affect; and (4) the use of exploratory change-oriented interventions (Weinberg, Ronningstam, Goldblatt, Schechter, & Maltsberger, 2011). The synthesis of these core principles leads to a certain set of attitudes and key principles, as shown in Table 2.

Table 2

Key principles for the treatment of personality disorders (Project Air Strategy for Personality Disorders, 2011).

Key Principles for Working with People with Personality Disorders

- 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 the person's capacity for change while validating their current emotional experience.

The Need for Step-Down Service Re-Design, Balancing Intensive with Brief Psychological Interventions

The mental health intake and emergency department data from a hospital system servicing a population of approximately 250,000 people are shown in Figure 1. Within this population, about 16,250 are estimated to have had diagnosable personality disorders based on population prevalence. Of the 6,338 inpatients of mental health services who presented at some time within a 4 year period, 1,584 unique people presented with a personality disorder. This represents 396 people per year (approximately one each day) who were admitted. It is important to then ask: how do you treat 396 people per year using guidelines-based psychological therapy with finite resources? Currently, a service this size usually offers around two group plus individual therapy personality disorder programs with places for about 40 clients a year, with each of the eight specialist staff taking about five clients each for psychological therapy. To meet the demands for the other 356 clients, and to avoid care that is not supported by clinical guidelines (such as long-term inpatient care or off-label pharmacotherapy), step-down approaches based on brief structured psychological therapy are required. These briefer interventions can specifically intervene when clients are in crisis and presenting to services, thus creating an opportunity to divert BPD clients from inpatient and emergency departments into rapid follow-up psychological care. Using a model adapted from St Vincent's Hospital Sydney (Wilhelm et al., 2007), we have developed a brief psychological intervention focused specifically on BPD clients in crisis. This aims to help overcome the crisis and develop a care plan to assist the client to be actively involved in their recovery. With 16 multidisciplinary staff offering brief intervention sessions over three locations, 450 places are made available each year so that all clients can be offered an appointment within 1–3 days to discuss their difficulties using a psychological approach supported by evidence-based clinical guidelines. Significantly, these sessions include one session that is set aside to connect with carers, family, and partners of the identified client; this is based on our research showing that these carers typically suffer significant burden, stigma, and distress that can be addressed through psychoeducation and carer planning that also have benefits for the client (Bailey & Grenyer, 2014).

Re-thinking BPD: The Project Air Strategy

Given the high prevalence of the disorder, the challenges of providing sufficient resources to meet clinical need, the stigma and burden for those involved, and the cost-benefit of intervening effectively, led the NSW Government in 2009 to recognise the need to re-think treatment approaches. The Project Air Strategy for Personality Disorders (2011) is a collaboration between NSW Health and the Illawarra Health and Medical Research Institute. It was awarded a competitive tender in 2010 to improve the capacity of mainstream mental health services to manage and treat personality disorder and to expand specialist treatment options, including improved referral pathways between generic and specialist treatment. The strategy aims to enhance treatment options for people with personality disorder and their families and carers. A close association with similar groups providing services in the area of personality disorders, including the Spectrum Personality Disorder Service for Victoria and Orygen Youth Health, has provided essential peer review and opportunities for collaboration.

The strategy adopted a relational model based on the understanding that personality disorders have been described as disorders of relationship, with three key relationships of particular focus: (1) the relationship between the client and themself, which in BPD is frequently characterised by extreme self-criticism and low self-esteem. A factor analysis of the nine BPD diagnostic criteria described three over-arching themes as 'affect dysregulation' (describing the mood and anger impulsivity), 'rejection sensitivity' (describing the interpersonal hypersensitivity including abandonment, anxiety, and emptiness), and 'mentalisation failure' (describing the identity disturbance and transient psychotic symptoms) (Lewis, Caputi, & Grenyer, 2012); the relationship between the client and health professionals, which is known to be both a key to success and conflictual and difficult to manage, incorporates hostile, narcissistic, compliant, anxious, and sexualised dimensions (Bourke & Grenyer, 2013); and (3) the relationship between the client and the

broader environment, including families, education, health, and community services, which can be characterised by ambivalence in the capacity and willingness to provide adequate support (NIMHE, 2003).

All evidence-based treatments work to target the first relationship component, some incorporate strategies to assist with the second, but few address the third component including the broader context. The field needs to move beyond an exclusive focus on the individual's intrapsychic difficulties to an interpersonal focus that includes health professionals, families, educators, employers, and communities within a recovery framework. Supporting the relationship model is the technology of the Core Conflictual Relationship Theme, which describes the interaction among client needs, wishes, and goals, the responses of others (including the therapist, partners, and family), and the response of self within an interpersonal dynamic (Bourke & Grenyer 2010; Grenyer, 2012). Using such a relationship model allows a broader understanding of what has been described as the dialectic between support and change, which applies to both the client's difficulties and the clinical and social environment.

At the commencement of the Project Air Strategy, the team undertook a series of research and evaluation studies to determine the shape of the implementation plan. These included collecting data from front-line clinical staff involved in the treatment of personality disorders (McCarthy, Carter, & Grenyer, 2013), conducting focus groups on the need for change (Fanaian, Lewis, & Grenyer, 2013), reviewing the literature (Bailey & Grenyer, 2013), seeking the views of experts on the advisory committee, obtaining peer review from an international audience (Grenyer & Carter, 2011), and ensuring the proposals met national and international guidelines (Grenyer, 2013). In addition, key findings from implementation science studies were incorporated, including the need for working with managers, involving key 'champion' clinicians, and ensuring that consumers played a role in reviewing the proposals. A whole of service approach was chosen. Training all mental health staff was designed to reduce stigma and therapeutic nihilism surrounding this client group and to facilitate the adoption of more hopeful and evidence-based attitudes towards treatments. Therefore, working with managers was also important to ensure support for the project within a relational model. Including families, carers, and consumers in the service redesign, and offering specific education, provided an opportunity to overcome previous barriers to support.

Developing 'easy to learn' brief interventions also worked to help health services manage the large volumes of clinical demand from this client group. At the commencement of the project, specialist longer-term treatments in the implementation sites were struggling with waiting lists of one to two years length, with little prospect of effectively meeting the demands of the large numbers of this treatment seeking group. Step-down services with rapid follow-up that provided diversion from emergency and inpatient units was a key innovation of the model developed. The central role of assessment and care planning provided individuals with a sense of direction and purpose that integrated the large number of community options available to them both from government and non-government service providers, including the mental health service. The project has delivered education and supervision programs in addition to the provision of expert interventions, treatment guidelines, and complex care reviews for a small number of high needs complex clients. Figure 2 shows the six key strategies as redesigning services, upgrading mental health staff skills, evaluating outcomes, connecting with families, carers, and consumers, improving awareness and information, and enhancing the quality of clinical services.

Figure 2. Six components of the Project Air Strategy for personality disorders.

The project model has been operationalised through clinical guidelines which describe the pathway of a client through the health service, from assessment and care planning, brief and longer term therapies, the role of inpatient and community care, interaction with general practitioners, involving families and carers, and systemic issues for services (Project Air Strategy, 2011). The operationalisation of the strategy involves a combination of senior management leadership, training and support, clinical leadership within services by experienced staff, and the design of service models to enhance clinical pathways using guidelines-based treatment to match client need. Core to the strategy is the role of clinical psychologists who act as the pivot point to coordinate the flow of clients into brief and more intensive treatments, and who lead the local consultation team. Essential to the strategy is collaborative care planning to assist in the coordination and integration of services, including a core leadership role for clinical psychologists assisting physicians, public and private psychiatrists, community services, emergency departments, non-government agencies, community housing, and other relevant services, based on a collaborative assessment of needs. Brief interventions, and family and carer sessions and workshops, complement more traditional extended group and individual therapies. The needs of children of persons with a personality disorder are one example of how the model focuses on the broader social context of care through enhanced parenting interventions.

Conclusion

The challenge for the field is no longer whether psychological treatments work. There is now a variety of models and methods which, for the right clients, can sustain their improvement and retain them in meaningful treatment, sometimes for up to three years (Grenyer, 2007). The next challenge is how to ensure models are available that allow step-down care, with both short and longer term options, to meet client need and the capacity of health services to respond. The sobering conclusion of a recent systematic review into BPD stated "there is evidence that psychotherapy is beneficial with respect to some clinically relevant problems of patients with borderline personality disorder. However, the available forms of psychotherapy do not yet lead to remission of borderline personality disorder for most patients" (Leichsenring et al., 2011, p. 80). High drop-out rates remain a challenge for the field, with a large number of clients unable or unwilling to commit to the established longer forms of treatment. Nevertheless, research on the treatment careers of psychotherapy clients typically shows that at least 90% presenting for help come with histories of previous treatment that accumulatively has benefited them (see, for example, Grenyer, Deane, & Lewis 2008). Every treatment interaction, however brief, is an opportunity to reinforce skills and to challenge beliefs about a client's capacity to be helped. It has been known for a long time that teams can be easily fractured and split into groups of clinicians who like and want to help, and groups who dislike and are unwilling to help, borderline clients (Main, 1957). The challenge before us is to both treat a patient's intrapsychic problems, and simultaneously support teams and the broader social and emotional environment, to maintain hope and compassion. The Project Air Strategy is one comprehensive relational approach that integrates both individual consultation with broader social and emotional engagement with services, families, carers, and the community to promote needed whole of service guidelines-based care.

References

Bailey, R. C., & Grenyer, B. F. S. (2013). Burden and support needs of carers of persons with personality disorder: A systematic review. *Harvard Review of Psychiatry, 21*(5), 248–258.

Bailey, R. C., & Grenyer, B. F. S. (in press). Supporting a person with personality disorder: A study of carer burden and wellbeing. *Journal of Personality Disorders*. e-View Ahead of Print. doi: 10.1521/pedi_2014_28_136

Bourke, M., & Grenyer, B. F. S. (2013). Therapists' accounts of psychotherapy process associated with treating borderline personality disorder. *Journal of Personality Disorders, 27*(6), 735–745. doi: 10.1521/ pedi_2013_27_108

Bourke, M. E., & Grenyer, B. F. S. (2010). Psychotherapists' response to borderline personality disorder: A core conflictual relationship theme analysis. *Psychotherapy Research, 20*(6), 680–691.

Butler, T., Andrews, G., Allnutt, S., Sakashita, C., Smith, N. E., & Basson, J. (2006). Mental disorders in Australian prisoners: A comparison with a community sample. *Australian and New Zealand Journal of Psychiatry, 40*(3), 272–276.

Davison, S., & Janca, A. (2012). Personality disorder and criminal behaviour: What is the nature of the relationship? *Current Opinion in Psychiatry, 25*(1), 39–45.

Fanaian, M., Lewis, K., & Grenyer, B. F. S. (2013). Improving services for people with personality disorders: The views of experienced clinicians. *International Journal of Mental Health Nursing, 22*(5), 465–471.

Grenyer, B. F. S. (2007). Hope for sustaining a positive three-year therapeutic relationship with borderline patients. *Archives of General Psychiatry, 64*, 609.

Grenyer, B. F. S. (2012). The clinician's dilemma: Core conflictual relationship themes in personality disorders. *ACPARIAN, 4*, 25–27.

Grenyer, B. F. S. (2013). Improved prognosis for borderline personality disorder: New treatment guidelines outline specific communication strategies that work. *Medical Journal of Australia, 198*(9), 464–465.

Grenyer, B. F. S., & Carter, P. (2011). Psychotherapy for borderline personality disorder: Where to start, when to finish? *Journal of Personality Disorders, 25*(Suppl 1), 9–10.

Grenyer, B. F. S., Deane, F. P., & Lewis, K. (2008). Treatment history and its relationship to outcome in psychotherapy for depression. *Counselling and Psychotherapy Research, 8*, 21–27.

Jackson, H. J., & Burgess, P. M. (2000). Personality disorders in the community: A report from the Australian National Survey of Mental Health and Wellbeing. *Social Psychiatry and Psychiatric Epidemiology, 35*(12), 531–538.

Johnson, J. G., Cohen, P., Smailes, E., Kasen, S., Oldham, J. M., Skodol, A. E., & Brook, J. S. (2000). Adolescent personality disorders associated with violence and criminal behavior during adolescence and early adulthood. *American Journal of Psychiatry, 157*(9), 1406–1412.

Korzekwa, M. I., Dell, P. F., Links, P. S., Thabane, L., & Webb, S. P. (2008). Estimating the prevalence of borderline personality disorder in psychiatric outpatients using a two-phase procedure. *Comprehensive Psychiatry, 49*(4), 380–386.

Leichsenring, F., Leibing, E., Kruse, J., New, A. S., & Leweke, F. (2011). Borderline personality disorder. *Lancet, 377*, 74–84.

Lenzenweger, M. F. (2008). Epidemiology of personality disorders. *Psychiatric Clinics of North America, 31*, 395–403.

Lewis, K., Caputi, P., & Grenyer, B. F. S. (2012). Borderline personality disorder subtypes: A factor analysis of the DSM-IV criteria. *Personality and Mental Health, 6*, 196–206. DOI 10.1002/pmh.1183

Lim, D., Sanderson, K., & Andrews, G. (2000). Lost productivity among full-time workers with mental illness. *Journal of Mental Health and Policy Economics, 3*, 139–146.

Main, T. F. (1957). The ailment. *British Journal of Medical Psychology, 30*, 129–145.

McCarthy, K. L., Carter, P. E., & Grenyer, B. F. S. (2013). Challenges to getting evidence into practice: expert clinician perspectives on psychotherapy for personality disorders. *Journal of Mental Health, 22*(6), 482–491.

National Health and Medical Research Council. (2012). *Clinical practice guideline for the management of borderline personality disorder*. Melbourne, Australia: Author.

Project Air Strategy for Personality Disorders. (2011). *Treatment guidelines for personality disorders.* Sydney, Australia: NSW Health and Illawarra Health and Medical

Research Institute. Retrieved from www.projectairstrategy.org

Smith, N., & Trimboli, L. (2010). Comorbid substance and non-substance mental health disorders and re-offending among NSW prisoners. *Crime and Justice Bulletin, no. 140*, pp. 1–16. Retrieved from http://www.bocsar.nsw.gov.au/agdbasev7wr/bocsar/documents/pdf/cjb140.pdf

Soeteman, D. I., Roijen, L., Verheul, R., & Busschback, J. J. (2008). The economic burden of personality disorders in mental health care. *Journal of Clinical Psychiatry, 69*(2), 259–265.

Steiner, H., Cauffman, E., & Duxbury, E. (1999). Personality traits in juvenile delinquents: Relation to criminal behavior and recidivism. *Journal of the American Academy of Child & Adolescent Psychiatry, 38*(3), 256–262.

Stevenson, J., & Meares, R. (1999). Psychotherapy with borderline patients: II. A preliminary cost benefit study. *Australian and New Zealand Journal of Psychiatry, 33*(4), 473–481.

Weinberg, I., Ronningstam, E., Goldblatt, M. J., Schechter, M., & Maltsberger, J. T. (2011) Common factors in empirically supported treatments of borderline personality disorder. *Current Psychiatry Reports, 13*(1), 60–68.

Wilhelm, K., Finch, A., Kotze, B., Arnold, K., McDonald, G., Sternhell, & Hudson, B. (2007). The Green Card clinic: Overview of a brief patient-centred intervention following deliberate self-harm. *Australasian Psychiatry, 15*(1), 35–41.

Zimmerman, M., Rothschild, L., & Chelminski, I. (2005). The prevalence of DSM-IV personality disorders in psychiatric outpatients. *American Journal of Psychiatry, 162*(10), 1911–1918.

Erratum

Fitzgerald, J. (2014). Emotionally focused therapy for couples: A brief overview. *The ACPARIAN, 8*, 4–6.
The third sentence of the third paragraph should read:

As the therapist respectfully reaches behind the masks of reactive angry pursuit and fearful withdrawal, the typical patterns of conflict and alienation, a distressed couple is helped to understand their distress more deeply. They are not coached to behave or talk in a certain way…

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