

# Personality disorder: the state of the evidence

April 2011

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# Prevalence of personality disorder in prison



	<b>Male Remand</b>	<b>Male Sentenced</b>	<b>Female All</b>
<i>Per cent</i>			

## **Type of personality disorder**

Antisocial	63	49	31
Paranoid	29	20	16
Borderline	23	14	20
Avoidant	14	7	11
Obsessive-compulsive	7	10	10
Narcissistic	8	7	6
Schizoid	8	6	4
Dependent	4	1	5
Schizotypal	2	2	4
Histrionic	1	2	1
<b>Any personality disorder</b>	<b>78</b>	<b>64</b>	<b>50</b>

*“Those of us with personality disorder can elicit a negative response and a kind of aloofness from professionals and carers, probably because we are a mass of churning emotions and, unintentionally, this is threatening to others, or stirs up their own deep-seated emotions.”*



Evidence...

# Drug treatment

- Ten small (total n=554), short, randomised studies involving eight comparisons producing usable data. (Binks 2006)
  - Duration  $\leq 6/12$
  - Newspaper recruits
  - 4 antidepressant trials, 6 antipsychotic trials, 2 mood stabilizer trials
  - 50% dropout in antipsychotic drug treatment by 12w



# Drug treatment

- ‘Pharmacological treatment of people with BPD is not based on good evidence from trials ...[but]... current trials suggest that the positive effect of antidepressants, in particular, could be considerable. (Binks 2006)



# NICE guidelines CG78 2009

- 1.3.5.1 Drug treatment should not be used specifically for borderline personality disorder or for the individual symptoms or behaviour associated with the disorder (for example, repeated self-harm, marked emotional instability, risk-taking behaviour and transient psychotic symptoms).
- 1.3.5.2 Antipsychotic drugs should not be used for the medium- and long-term treatment of borderline personality disorder.



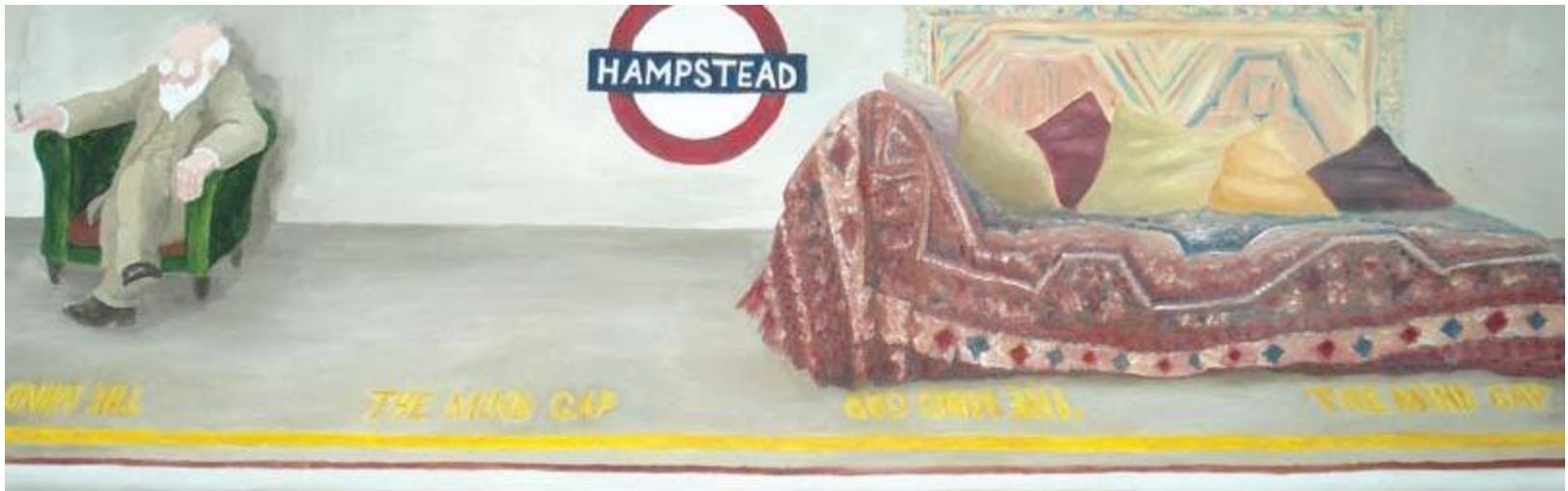
# NICE guidelines CG78 2009

- 1.3.5.3 Drug treatment may be considered in the overall treatment of comorbid conditions.
- 1.3.5.4 Short-term use of sedative medication may be considered cautiously as part of the overall treatment plan for people with borderline personality disorder in a crisis. The duration of treatment should be agreed with them, but should be no longer than 1 week .



# Evidence for effective treatment of BPD: psychological approaches

- Psychotherapy: seven studies involving 262 people, five separate comparisons
- ‘... all therapies remain experimental and the studies are too few and small to inspire full confidence in their results.’ (Binks 2006)
  - DBT. Inconsistent results over fu period/mixed results/ns
  - Psychoanalytically oriented partial hospitalisation

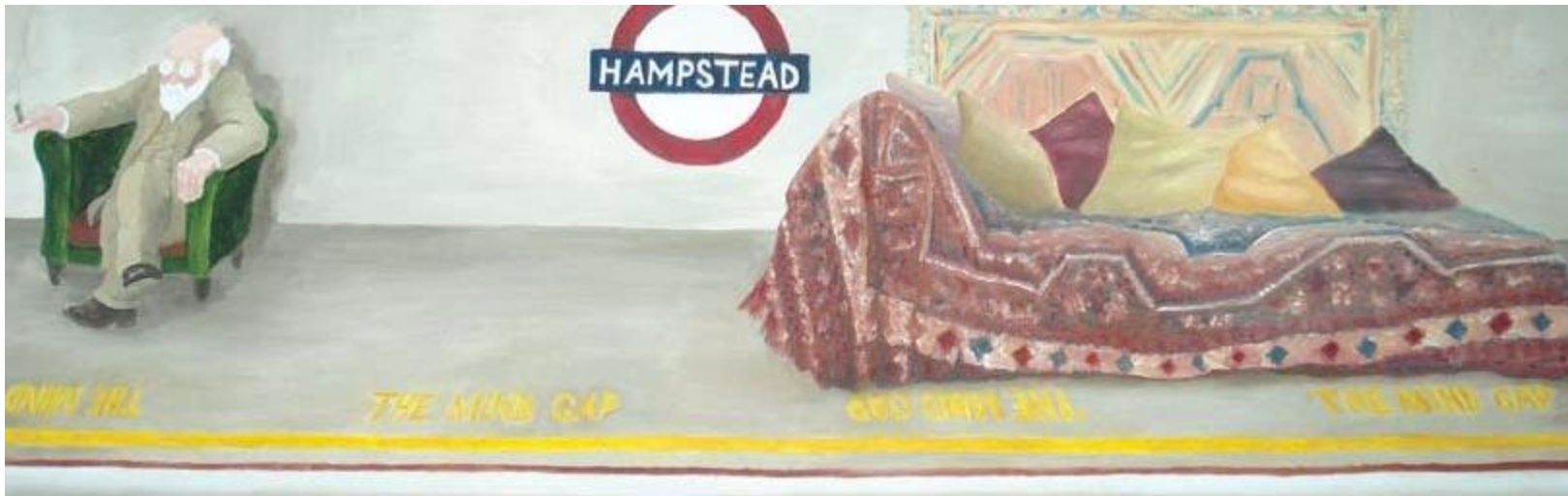


# Developments since 2006

- STEPPS (Blum 2008)
- CBT (Davidson 2009)
- SFT/TFP (Giesen-Bloo 2006)
- MBT follow-up (Bateman 2008)
- DBT further trials (Linehan 2006)
- DBT v TFP v support (Clarkin 2007)
- Social problem solving (Huband 2007)
- ISTDP (Abbass 2008)

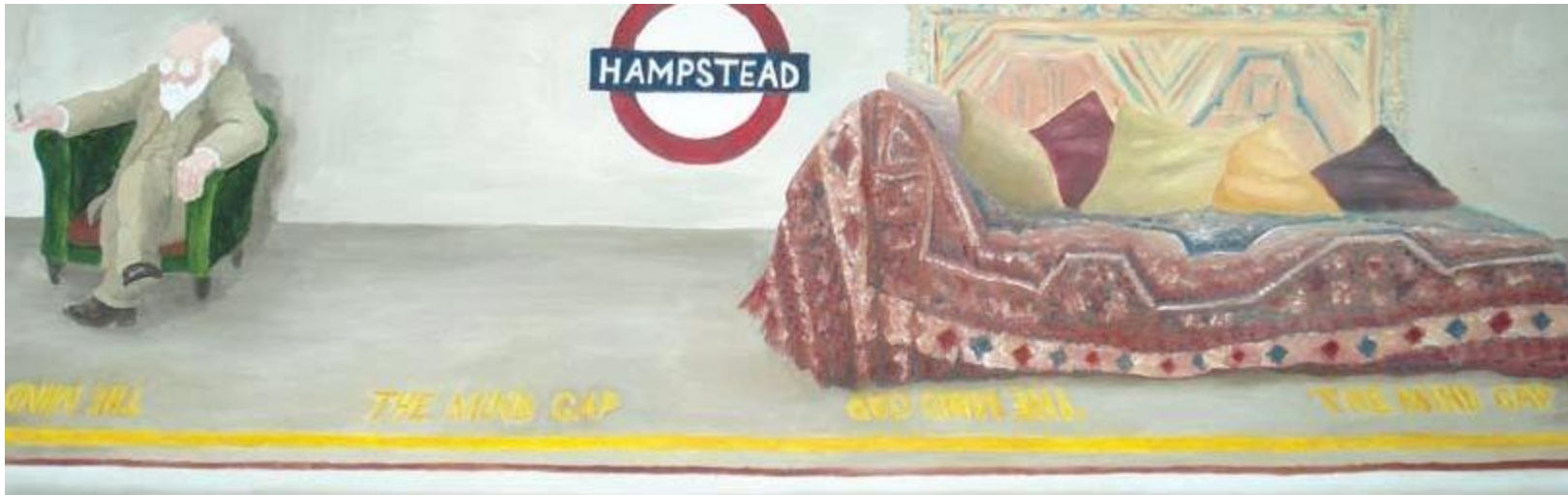


# NICE recommendations



- For women with borderline personality disorder for whom reducing recurrent self-harm is a priority, consider a comprehensive dialectical behaviour therapy programme.
- Do not use brief psychological interventions (of less than 3 months' duration) specifically for borderline personality disorder or for the individual symptoms of the disorder, *outside a service that has the characteristics outlined in 1.3.4.3.*

# NICE recommendations

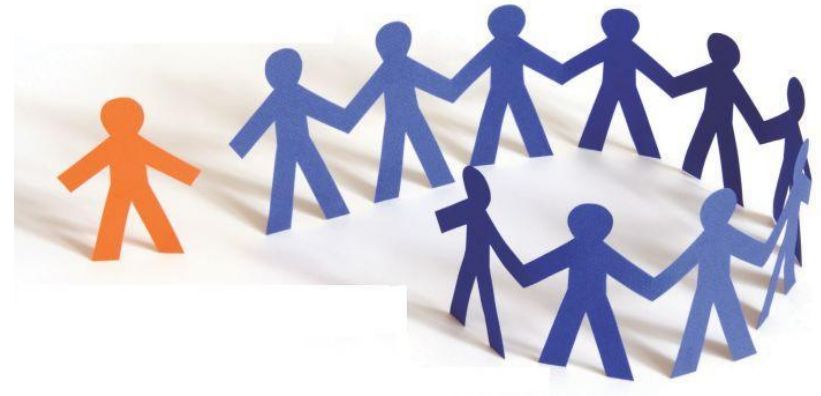


1.3.4.3 When providing psychological treatment for people with borderline personality disorder, especially those with multiple comorbidities and/or severe impairment, the following service characteristics should be in place:

- an explicit and integrated theoretical approach used by both the treatment team and the therapist, which is shared with the service user
- structured care in accordance with this guideline
- provision for therapist supervision.

# NICE recommendations

- 1.1.1.1 People with BPD should not be excluded from any health or social care because of their diagnosis or because they have self-harmed
- 1.1.5.1....inform families or carers about local support groups for families or carers, if these exist.



# Admission

- Can be difficult to manage
- More antisocial behaviour when assertive community based treatment is used (Gandhi et al, 2001)
- Depression and social functioning improved more with hospital based treatment than community based treatment for psychiatric emergencies (Tyrer 1994)



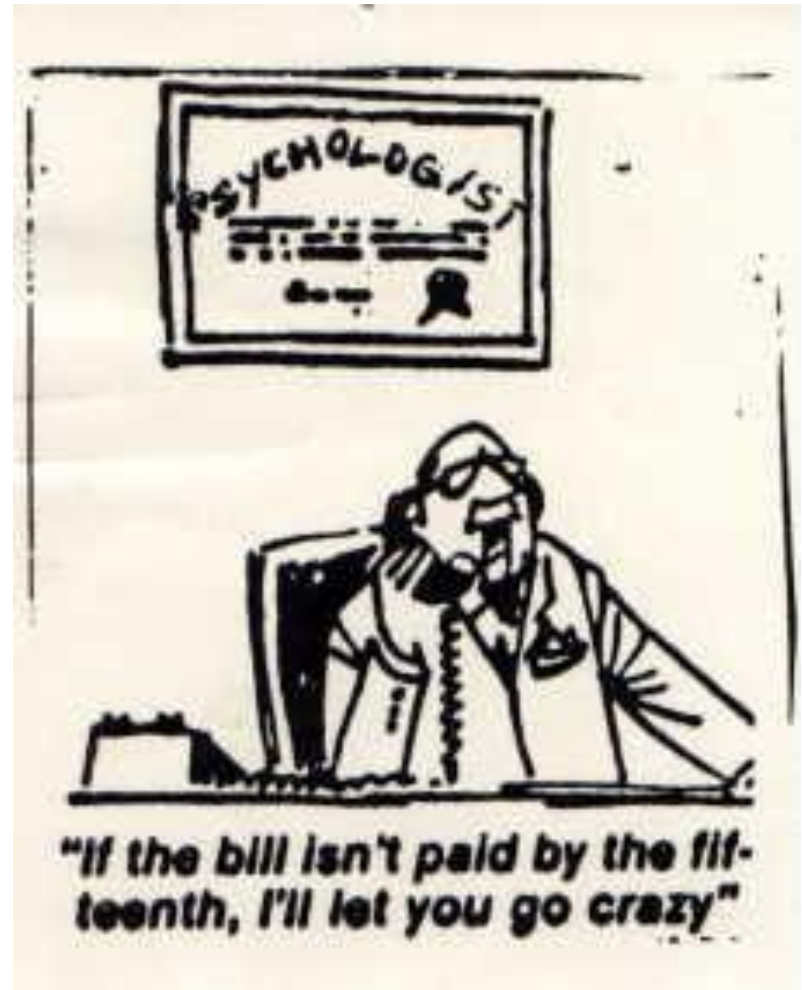
# Admission

- Fewer attachment and support figures – CMHTs unlikely to be able to provide support necessary when function deteriorates
- Early evidence that centres favouring hospitalisation may have increased frequency of repeat DSH (Bennewith 2001)



# Cost benefit research

- Cassel 18/12 treatment
  - Average per annum saving of £7,423 per patient (May 1992 costs) (Chiesa 1996)
- Henderson 12/12 treatment
  - £14,000pa before Rx, £1300 after Rx. Cost of Rx £25,000 (Menzies 1993)
- Bateman 2003
  - \$12,000 pa saving after Rx



# Research on PD teams

- The personal qualities of staff – such as self-awareness and ability to observe boundaries – are more relevant ... than professional qualifications
- Training ... to teams, rather than individuals
- Teams ... should have regular input from an ‘expert by experience’ (a service-user worker)



# Protecting against burnout

- Teamwork
- Strong leadership
- Opportunities for reflective practice



Crawford 2010

# NICE on training

- 1.1.9.1 Mental health professionals ... should be trained to diagnose borderline personality disorder, assess risk and need, and provide treatment and management in accordance with this guideline.



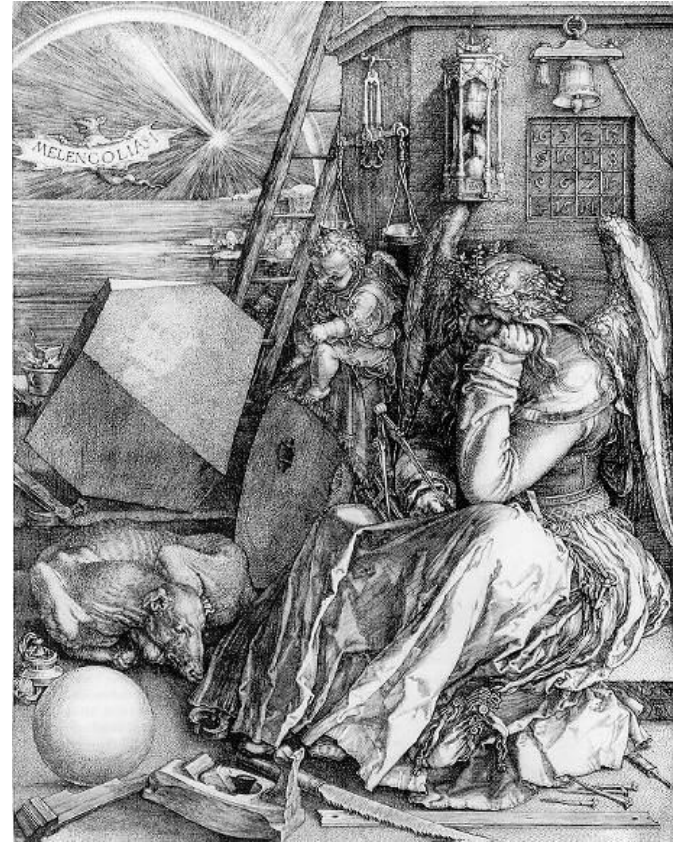
# General principles of PD management

- Experience of being the subject of reliable, coherent and rational thinking
- Have mostly been deprived of consideration and commitment during early development
- ... and quite frequently in later life



# Management in primary care

- Manage expectations
- Interpersonal focus
- Affect focus - arousal
- Power and agency
- Don't be put off by the label
- Supervision



# Management principles

- Consistency
  - all professionals substantially involved should maintain contact
- Attention to countertransference (reflective practice)
  - blaming
  - assumption that unconscious processes are conscious
  - understanding past and present dynamics, avoiding falling into same roles
  - supervision
- Special patients
  - ‘The Ailment’, Main 1968
  - boundaries

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*“O.K.—but just this once”*

# Management principles

- Avoid reinforcing unhelpful behaviours
  - attachment rather than rule based
- Encourage reflection and agency in decisions, explaining rationale
- Medication
- Pay attention to the meaning of behaviour, including self harm

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*"I think the dosage needs adjusting. I'm not nearly as happy as the people in the ads."*

End