



Scoping review on personality disorder

January 2019



Professor Gavin Davidson
Praxis Chair of Social Care
School of Social Sciences, Education
and Social Work
g.davidson@qub.ac.uk

Overview of the presentation

- Scoping review approach
- Definition and prevalence
- NI context
- Theoretical perspectives
- Evidence base for interventions
- Complex needs
- Recovery
- Support for staff

Scoping reviews

- This type of review provides a preliminary assessment of the potential size and scope of available research literature
- It aims to identify the nature and extent of research evidence
- Identify areas where a full systematic may be needed
- Don't tend to include process of quality assessment
- Cannot usually be regarded as a final output in their own right

(Grant and Booth, 2009)

Scoping review methodology

- Searched Google Scholar, National Institute for Health and Care Excellence (NICE) Evidence Search, Zetoc, Social Care Online and Web of Science
- Main search terms: “personality disorder”; “systematic review”; “Northern Ireland”; “recovery”
- Selection: focused on systematic reviews if available, most recent research and innovative service developments

Definition and prevalence (Mental Health Foundation)

- No one agreed comprehensive definition of personality disorder (PD)
- ‘Generally affects how an individual copes with life, how they manage emotions and connect with other people. People with a PD may find that their beliefs and attitudes are different from most people who may find their behaviour unusual, unexpected or even offensive at times’
- ‘Difficulties may include: making or maintaining relationships; connecting with other people, including friends, family or work colleagues; managing and controlling their emotions; coping with life and difficult feelings; and controlling their behaviours and impulses’
- Associated with self-harm, suicide, substance misuse, and other mental health problems
- Estimated that 1 in 20 people have a PD

Definition and prevalence (NI PD Strategy 2010)

Population Studied	Prevalence of PD
Community	5%-11%
Primary Care Attenders	10%-30%
Psychiatric Outpatients	30%-40%
Psychiatric Inpatients	36%-67%
Prisoners	60%-80%

Definition ICD-11 (December 2018)

- Personality disorder is characterized by problems in functioning of aspects of the self and/or interpersonal dysfunction that have persisted over an extended period of time (e.g., 2 years or more). The disturbance is manifest in patterns of cognition, emotional experience, emotional expression, and behaviour that are maladaptive (e.g., inflexible or poorly regulated) and is manifest across a range of personal and social situations (i.e., is not limited to specific relationships or social roles).
- Not developmentally appropriate and cannot be explained primarily by social or cultural factors, including socio-political conflict
- The disturbance is associated with substantial distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

Definition

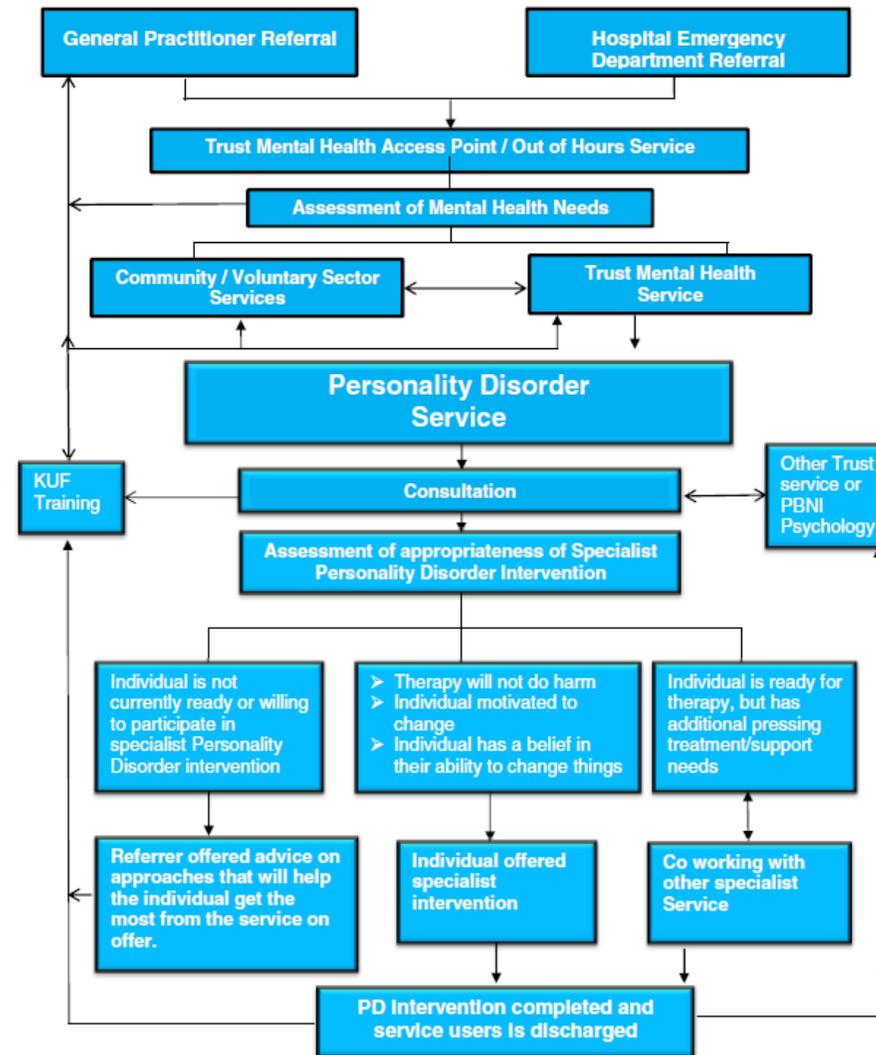
- Range of classifications but generally six PD types
- borderline personality disorder (BPD); obsessive compulsive personality disorder (OCPD); avoidant personality disorder (AvPD); schizotypal personality disorder (STPD); antisocial personality disorder (ASPD); narcissistic personality disorder (NPD)
- And/or 3 groups or clusters which bear similar characteristics.
- Cluster A- ‘Odd or eccentric’ types (paranoid, schizoid, schizotypal)
- Cluster B – ‘dramatic, emotional or erratic’ types (borderline, narcissistic, anti-social)
- Cluster C – ‘anxious and fearful’ types (obsessive/compulsive, dependent, avoidant)
- Ongoing debate – association with trauma; judgmental, negative and stigmatizing
- Specific exclusion under MHO (by reason only of)
- ‘People with personality disorder have problems in interpersonal relationships [including staff] but often attribute them wrongly to others’
- (Tyrer et al., 2015, p.717)

NI context – NI PD Strategy

- DHSSPS, 2010, Personality disorder: A diagnosis for inclusion. The Northern Ireland Personality Disorder Strategy
- Approximately 10% of people with a PD go on to complete suicide, while 12% of all people who complete suicide are considered to have a PD
- It is generally acknowledged that personality disorders are caused by a combination and interaction of genetic vulnerability and ACEs
- Services should be developed across tiers 0-3, working alongside and linking with existing health and social care and criminal justice services, and involving housing, employment and leisure agencies
- A specific prioritised role for those working in tier 3 services would be to minimise the need for transfer of people outside of NI

NI context – Regional Care Pathway

- DHSSPS, 2017, Regional Care Pathway for Personality Disorders



NI context – Regional Care Pathway

- The Knowledge and Understanding Framework (KUF) provides awareness and skills training for staff, service users and carers (www.personalitydisorderkuf.org.uk). KUF Level 1 awareness training will be available and is recommended for a broad range of Health, Social Care and Criminal Justice staff who frequently work with people with personality based difficulties.

Theoretical perspectives

- Bio-psychosocial model
- Consensus statement 2018 – ‘This diagnostic label should be helpful because it can act as a gateway for individuals to access the care they need. Unfortunately all too often it can be used as a reason to reject individuals from services. Most of us would rather not use the term at all
- Association with past trauma
- People given the diagnosis of personality disorder have often experienced complex social and system failures early in life, leading to chronic difficulties in developing and maintaining sustainable adult identity and functioning which can affect how they engage with all services – not just those focused on mental health’

Theoretical perspectives

- ‘Rather than being very stable, we now know that both normal and abnormal personality can change trajectory across the lifespan
- We also now know that personality disorder is treatable and has acute manifestations that are amenable to intervention
- Even characteristic traits can change with time, especially when helped with effective evidence based treatments that might work, in part, by catalysing delayed maturational’ (Newton-Howes et al., 2015)
- Dodo Bird verdict – ‘current situation relating to treatments for BPD, with effect sizes from both cognitively and psychodynamically oriented therapies indicating effectiveness’ (Byrne and Egan, 2018, 182)

Evidence base (Bateman et al., 2015)

- The evidence base for the effective treatment of personality disorders is insufficient
- Most of the existing evidence on personality disorder is for the treatment of borderline personality disorder, but even this is limited by the small sample sizes and short follow-up in clinical trials
- Psychological or psychosocial intervention is recommended as the primary treatment for borderline personality disorder
- Pharmacotherapy is only advised as an adjunctive treatment
- Research about the underlying, abnormal, psychological or biological processes leading to the manifestation of a disordered personality is increasing, which could lead to more effective interventions.

Evidence base

- Systematic review of psychotherapies for BPD (Cristea et al., 2017)
- Psychotherapies, most notably dialectical behaviour therapy and psychodynamic approaches, are effective for borderline symptoms and related problems. Nonetheless, effects are small, inflated by risk of bias and publication bias, and particularly unstable at follow-up.
- Systematic review of social outcomes (Connell et al., 2017)
- There is a lack of evidence for effective interventions that improve social outcomes. Further research is recommended to reach consensus on the outcomes of importance, identify the factors that influence these and design theoretically-informed and evidence-based interventions.

Evidence base – focus on BPD and anti-social PD NICE, 2018

- When providing psychological treatment:
- ensure that the following service characteristics are in place, especially for people with multiple comorbidities and/or severe impairment:
- an explicit and integrated theoretical approach used by both treatment team and therapist and shared with the service user
- structured care in accordance with these recommendations
- provision for therapist supervision.
- Do not use: drug treatment specifically for borderline personality disorder or for the individual symptoms or behaviour associated with the disorder

Evidence base – focus on BPD and anti-social PD NICE, 2018

- For people with antisocial personality disorder, including those with substance misuse problems, in community and mental health services, consider offering group-based cognitive and behavioural interventions, in order to address problems such as impulsivity, interpersonal difficulties and antisocial behaviour.
- For people with antisocial personality disorder with a history of offending behaviour who are in community and institutional care, consider offering group-based cognitive and behavioural interventions (for example, programmes such as 'reasoning and rehabilitation') focused on reducing offending and other antisocial behaviour.
- Pharmacological interventions should not be routinely used for the treatment of antisocial personality disorder or associated behaviours of aggression, anger and impulsivity.

Complex needs

- ‘Sexual abuse was found to play a major role in BPD, particularly in women. Childhood sexual abuse is an important risk factor for BPD. Adult sexual abuse rates are significantly higher in BPD patients compared with other personality disorders. SA history predicts more severe clinical presentation and poorer prognosis. Suicidality has the strongest evidence, followed by self-mutilation, post-traumatic stress disorder, dissociation and chronicity of BPD.’ (Ferreira et al., 2018, p. 70)
- Alcohol use disorders – ‘People with antisocial PD had the highest lifetime AUD prevalence, at 76.7%, followed by those with borderline PD at 52.2%, while those with other forms of PD, or undifferentiated PD, had a prevalence of 38.9%...The majority of people with PD experience an AUD at some time in the life course.’ (Guy et al., 2018, 216)



Complex needs

- Aggression in mental health residential facilities: A systematic review and meta-analysis (Bulgari et al., 2018) - History of violence, personality disorders, lifetime substance and alcohol misuse were found significantly associated with aggression.
- Intellectual disability, personality disorder and offending: a systematic review (Rayner et al., 2015) – ‘having co-morbid ID and PD makes one particularly vulnerable to acquiring a criminal record. Overall, these studies suggest that the presence of PD in a person with ID, particularly in men, is likely to be associated with increased dangerous offending.’ (p. 56)

Recovery

- Recovery from Borderline Personality Disorder: A Systematic Review of the Perspectives of Consumers, Clinicians, Family and Carers (Ng et al., 2016)
- ‘Although research into BPD has increased, limited attention has been placed on the lived experience of consumers and their support networks. The earliest article examining recovery from a consumer’s perspective was published as recently in 2011 and no articles on the recovery experiences from the perspective of clinicians, family and carers were identified.’ (p. 14)
- Personal recovery in personality disorder: Systematic review and meta-synthesis of qualitative methods studies (Shepherd et al., 2016) 3 studies included - Three novel higher order themes were developed: Safety and containment as a prerequisite to recovery, social networks and autonomy in the recovery process and identity construction as a process of change.

Support for staff

- Interventions to improve mental health nurses' skills, attitudes, and knowledge related to people with a diagnosis of borderline personality disorder: Systematic review (Dickens et al., 2016)
- Some evidence that staff have negative attitudes towards people with a diagnosis of borderline personality disorder and that this might impact negatively on the development of helpful therapeutic relationships
- Eight studies, awareness training positive especially for those with more negative attitudes and who didn't have previous specific training
- Regional Care Pathway - Risks should be managed by the whole multidisciplinary team, with good support and supervision for the key worker.