

Patients with personality disorders can be challenging for therapists.

Professional advances are constantly being made, however, providing grounds for cautious optimism.

Personality disorders in clinical practice

Personality disorders include a number of conditions and behavioural patterns that are stable. They represent extreme or significant departures from how the average individual in a given culture experiences, thinks and feels, and how they relate to others, and it is usual for them to experience considerable subjective distress and/or problems in family and working relationships.

In this edition of the Journal of the Norwegian Medical Association, Wilbert et al. have an article on the treatment of patients with personality disorders in psychiatric/psychological contracted practice (1). The study shows that there are a number of challenges: Some left the therapy, and there were also difficulties associated with substance abuse and other disinhibited behaviour. Even motivated and experienced therapists found that many patients failed to keep appointments, behaved in a disinhibited manner or completely dropped out of therapy. At the same time, many patients were satisfied with the treatment.

Whereas there used to be a tendency to regard these conditions as relatively refractory to treatment, in recent decades there has been increasing interest among researchers in developing effective therapy for personality disorders. This therapy has varied from hospitalisation to day hospitals to psychotherapy with contracted specialists as outpatients. Treatment by contracted specialists allows a continuity that it is less easy to achieve with inpatient treatment or regional psychiatric centres.

However there is wide variation in the problems and challenges presented by different personality disorders. Among the specific personality disorders (F60 group in ICD 10) there is a major difference between the dependent and avoidant, the emotionally unstable or dis-social and the paranoid or schizoid. While some need support and encouragement, others also need confrontation and boundary-setting. Many have complicated behaviour, with substance abuse and/or disinhibited behaviour. This may be difficult to handle in a psychiatric/psychological contracted practice, and before embarking on such treatment a thorough evaluation is necessary of whether the patient is suitable and motivated for psychotherapy. Patients who are more unstable and disinhibited may need a more mixed therapy option.

Patients with emotionally unstable personality disorder (F60.3) are a particular therapeutic challenge, partly because of their strong tendency to react emotionally and have shifting motivation. Over time, several methods have been developed for treating these patients. The most important are dialectical behaviour therapy, mentalisation-based therapy, transference-focused therapy and transference- and schema-focused therapy (2). The general conclusion is that psychotherapy is effective, but that there is no basis for strongly recommending any one method rather than another. In a Norwegian study, mentalisation-based therapy yielded better results than traditional psychotherapy (3). An important aspect of the intervention is developing the ability to integrate thought and emotion. The method led to fewer patients dropping out of the therapy, less symptoms and better psychosocial function than the comparison group, who received more traditional psychotherapy.

There is a need for psychiatrists and psychologists to develop specialist expertise in some diagnostic subgroups. A therapist may be excellent for treating a patient with a dependent or avoidant personality disorder, but may have difficulties with patients with disinhibited behaviour who need boundary-setting. This may be because a different approach is required, or perhaps most frequently it is due to the personal traits of the therapist.

At a time of increasing expectations of efficacy and a short treatment time, there is a tendency to forget that many conditions are chronic, and hence cannot be treated fast. Many patients with personality disorders have had a difficult childhood characterised by instability, inappropriate stimuli and unclear boundaries. When a person who has developed a difficult relationship with themselves and others through many of the most formative years of their life, it is unrealistic to believe that a therapist should be able to correct this through a short-term intervention.

In the survey in question, a third of the patients were still in therapy after three years (1). The average number of hours of therapy was 43. The costs of this are roughly equivalent to a 1–2-week stay as an inpatient in a psychiatric hospital. The expenses associated with long-term psychotherapy are limited, and the opportunities for achieving insight, growth and development are greater than a brief acute inpatient period can offer.

Somatic health problems are common among patients with personality disorders, not least as a result of substance abuse, injuries and accidents. These patients are therefore treated in the somatic departments of hospitals, and not least in general practice and at A&E. Primary doctors are an essential link in the treatment chain by integrating treatment programmes and being stable contacts. Competence is therefore also necessary in this part of the health system. Primary doctors may benefit from guidance by a psychiatrist, while they can obtain help from the psychiatric consultation service (liaison) at somatic departments.

Many of these patients will be put on disability benefits at a young age after developing chronic conditions with growing psychosocial and somatic complications. Many also contribute strongly to the significant mortality attributable to substance abuse, accidents or suicide. The therapy will often be concerned primarily with trying to bring this negative trend to a halt. As somatic complications arise, other parts of the health service will also face an increasingly demanding task.

Despite all this, there is reason for cautious optimism when it comes to treating patients with personality disorders. The possibilities appear to be improving steadily for motivated patients, particularly when specific measures are developed and adapted to different subgroups.

Øivind Ekeberg
oivind.ekeberg@uus.no

Øivind Ekeberg is a specialist in psychiatry, senior consultant and head of the research unit of the Department of Acute Medicine, Oslo University Hospital, Ullevål, and an adjunct professor with the Department of Behavioural Science, Institute of Basal Medical Sciences, University of Oslo. The author has completed the ICMJE form and reports no conflicts of interest.

References

1. Wilberg T, Kvarstein EH, Røvik JO. Pasienter med personlighetsforstyrrelse i talepraksis. Tidsskr Nor Legeforen 2014; 134: 2267–71.
2. Stoffers JM, Völlm BA, Rücker G et al. Psychological therapies for people with borderline personality disorder. Cochrane Database Syst Rev 2012; 8: CD005652.
3. Kvarstein EH, Pedersen G, Urnes O et al. Changing from a traditional psychodynamic treatment programme to mentalization-based treatment for patients with borderline personality disorder – Does it make a difference? Psychol Psychother 2014; e-publisert 15.7.2014.