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Perspectives on the prevalence and treatment of personality disorder

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Personality disorder (PD) is the most prevalent psychiatric disorder. A methodical literature search identified that PD is under researched compared with other mental health problems such as depression or schizophrenia. Social and psychotherapeutic approaches emerge as dominant treatment approaches with PD where there is good evidence of efficacy. Collaborative group-based therapeutic approaches appear to offer a therapeutic counterpoise to the anti-social traits often prevalent in PD. A retrospective analysis of formal group therapy on acute inpatient units (treating PD patients among other mental health disorders) reveals only one violent incident in over 40 000 treatment hours of formal group therapy. It is argued that group-based and social therapy should be the recommended treatment approach because these approaches have been shown to create a safe and contained milieu, establishing a good base for therapeutic gain with PD patients. The case for widening the scope of collaborative group and community-based therapies is considered and the merits and shortcomings of a key worker system with PD patients are critiqued.

Keywords: group psychotherapy, key worker, personality disorder, social exclusion

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Personality disorder (PD): a diagnosis of exclusion?

In April 2005, the UK's Department of Health (DOH 2005) alerted us to the financial cost (up to £85 000 a year per patient) of the specialist residential based units that have been the main choice for treating patients identified as suffering from PD. Outcomes studies have, however, shown significant financial savings for PD patients treated in residential services like the Henderson for instance (Dolan *et al*. 1996). The desire to reduce the costs of treating PD through the devolution of financial and management responsibility to local Primary Care Trusts will not alleviate the high financial burden of PD. Indeed, it might be said that PD, with its high prevalence and heavy service usage, is the psychiatric condition most costly to the national purse. Patients with PD have often been excluded from services on the grounds of untreatability; the National Institute for Mental Health England found that: 'people with a primary diagnosis of PD are frequently unable to access the care they need' (NIMHE 2003a, p. 5). The DOH (2003) published *Personality Disorder – No Longer a Diagnosis of Exclusion* which advanced the idea that PD should been seen as a spectrum disorder, and that while some PD patients suffer severe and sometimes long-term consequences, meriting treatment in specialist high-secure hospitals, the vast majority of PD suffers are treated successfully in primary care.

Renewed interest in the social construction of mental illness has brought matters of social stigma and social exclusion back to the fore, particularly with government documents (cf. DOH 1990, 1999, NIMHE 2003b). In a

report from the Social Exclusion Unit (2004), attention was drawn to the dangers of social isolation for people suffering from mental illness. The report argued that by offering sustainable community networks, supportive neighbourhood services, work attachment and access to talking therapies, many mental illnesses, including PD, could be combated. Perhaps echoing the social psychiatry movement of the 1950s and 1960s, the new social exclusion agenda addresses a dislocation in the discourses of mental illness and social proximity which has been lacking during the 1980s and 1990s. It is here that we might advance a more workable understanding of the often misunderstood condition of PD.

PD prevalence

Personality disorder is unusual in psychiatric terms as an 'illness' that is widely accepted as having no major biological causal pathway. Personality disorder therefore can be seen as falling into a medical hinterland, where it is often regarded as 'not a genuine illness' but viewed as a problem of choice and self-control (Kendell 2002). Relative to depression and schizophrenia for instance, PD treatment has emerged outside the practice of treatment by medication. Nonetheless, patients with a diagnosis of PD mostly fall under the umbrella of psychiatric services. A large-scale US study of 664 patients with a diagnostic range of types of PD (e.g. schizotypal, borderline, avoidant and obsessive–compulsive) revealed more extensive histories of psychiatric outpatient, inpatient and psychopharmacologic treatment than any other psychiatric diagnoses (Bender *et al*. 2001). It has been estimated that the number of psychiatric outpatients with PD is somewhere between 20% and 40% with up to 50% of inpatients, rising to 66% in the male prison population (cf. Davison 2002). According to the Royal College of Psychiatrists, 13% of the population may be suffering from a PD (BBC News, 19 October 1999). It is estimated that about 2000 people in England and Wales fall into a specific category of dangerous and severe PD (DSPD) group, with 98% being male, mostly found in prison or secure hospitals.

There are nine categories of ICD-10 PD and 10 categories of DSM-IV for PD. National Institute for Mental Health in England (2003a) recommended a clustering of the subcategories of DSM-IV into Cluster A, paranoid, schizoid and schizotypical PD. Cluster B, histrionic, narcissistic, anti-social and borderline PD. Cluster C includes obsessive–compulsive, avoidant and depressive PD. However, allocating the right treatment pathway for each cluster is not outlined within this best practice guideline document, except to say that Cluster B patients attract the most attention presenting often in crisis of deliberate self-harm and risk of harm to others. The latest subcategory of PD, DSPD, creates a term that has sought a more stark distinction between PD and social norm (cf. Manning 2000, 2002) and has brought with it much controversy as it emerged not from clinical imperatives but rather from the Home Office (2001) following a public outcry concerning the case of Michael Stone, who bludgeoned Lin and Megan Russell to death in their home, in 1996. Tyrer (2002) put it must baldy and stated that: 'we know people are dangerous and we know people have personality disorders, what we don't know yet is that the link between the two is so strong that we can make a diagnosis of DSPD' (p. 10).

PD research compared with other conditions

Given the high prevalence of PD, and its expense to public funds, one might have expected that it was a condition that was well researched compared with other psychiatric illnesses. This hypothesis was tested using the *British Medical Journal*'s search facility (http://bmj.bmjjournals.com/search.dtl). All papers (title and abstract) were searched using terms related to 'personality disorder'. In the first place, the search was limited to include papers in British journals between 1966 and 2000. Papers were coded and aggregated by half decade. Other major topics were searched in the same manner using a list of terms and related terms for other mental health disorders (see Table 1).

The search was then repeated to include all journals outside the UK (see Table 2).

Table 1
UK papers searched by title and abstract for subject interest

	1966–1970	1971–1975	1976–1980	1981–1985	1986–1990	1991–1995	1996–2000
Depression	74	100	136	218	311	332	379
Schizophrenia	47	61	82	124	203	283	272
PD	2	2	9	9	24	51	39
OCD	0	1	0	5	14	15	18
Eating disorder	0	0	0	3	7	10	10
Hysteria	7	1	4	3	9	10	8
Sleep disorder	0	0	1	0	0	1	0

PD, personality disorder; OCD, obsessive–compulsive disorder.

Table 2
World papers searched by title and abstract for subject interest

	1966–1970	1971–1975	1976–1980	1981–1985	1986–1990	1991–1995	1996–2000	2001–2005
Depression	140	184	311	656	741	913	1397	2898
Schizophrenia	77	105	193	281	362	530	898	1189
PD	4	2	20	43	84	176	191	196
OCD	0	1	0	20	52	87	111	107
Eating disorder	0	0	0	5	15	30	35	178
Hysteria	0	0	0	5	16	27	32	21
Sleep disorder	9	5	13	9	9	14	18	252

PD, personality disorder; OCD, obsessive–compulsive disorder.

The results show the rank order of frequency of topics researched (see Tables 1 and 2). The search revealed a small but steady increase in papers written about PD, particularly in the USA, with a slight decline in interest over the past 5 years against other topics (particularly sleep and eating disorder). In the UK, there was a dip in the number of PD-related papers between 1996 and 2000, but overall the UK picture correlates closely with a global increase in literature about PD. Given the high clinical prevalence of PD across all branches of social, medical and health welfare, one might have anticipated a more significant research yield in terms of papers about PD. In conclusion, we can say that the number of scientific papers examining PD in leading psychiatric, sociological and psychological journals is relatively low, compared with papers examining Axis I disorders (such as depression and schizophrenia) and given that PD has a higher prevalence, research into PD is disproportionately low. This research skew might be accounted by a disinterest of pharmaceutical companies in the treatment of PD, that is to say, research sponsorship is greater for conditions believed to respond well to medication.

Efficacious treatments

Although there are contradictory findings in a range of studies examining treatment outcome with PD, overall there is evidence enough to suggest that PD should not be seen as an impediment to good treatment response (Bateman & Fonagy 2000, Mulder 2002). Exploratory psychotherapy has become the treatment of choice for PD and it is worth considering in more detail the evidence to support this (cf. Roth & Fonagy 2005). For example, Bernstein *et al*. (1996) completed a study in the USA, highlighting the developmental psychopathology of PD, tracking formative problems in a randomly selected community sample of 641 youths. They were initially assessed in childhood and followed longitudinally over 10 years. Problems in childhood were rated in terms of depressive symptoms, anxiety/fear and immaturity. All four of these putative childhood antecedents were found to be associated with greater odds of an adolescent PD. The study emphasized that the tool of 'depth or developmental psychology' could be pertinent in terms of diagnosing the aetiology of the disorder and then providing a foundation for advancing treatment.

Personality disorder treatment has developed most commonly within the orbit of dynamic psychotherapy, which might be clinically attuned given that PD has a clearly identifiable developmental causal pathways. Clinical procedures therein seek to explore life events that might have led to a damaged personality during development. The most persuasive data about the value of this exploratory psychotherapeutic approach with PD emerged from a randomized controlled trial carried out at the Halliwick Unit, St Anne's Hospital in north London (Bateman & Fonagy 1999). A programme of partial hospitalization (i.e. day time only) which included milieu psychotherapy, combined with formal psychodynamic intervention, was found to be effective in reducing hospitalization and self-harm, bringing about significant health gains in the treated cohort, compared with a control group who received general psychiatric intervention as usual. The health gains in the treated group were sustained over a follow-up period of 18 months. The researchers were unable to explain whether it was the milieu experience (in the day hospital) or the formal psychotherapy that was most efficacious, although it appears likely that a combination of the two approaches (psychodynamic psychotherapy and social interaction) proved most beneficial when compared with the control group.

Other results of psychotherapeutic approaches in the UK treating PD amassed during the 1990s. For example, Higgit & Fonagy (1992) identified evidence to support the value of therapeutic communities in treating borderline PDs and specifically singled out three specific service models of best practice (the Henderson Hospital Surrey, UK; the Cassel in Richmond, south-west London and Ward Six at the Maudsley in central south London). Higgit and Fonagy identified that the common approaches of these units were characterized by a combination of individual and group psychotherapy approaches. In particular, they noted that milieu appeared to function as a sanctuary for patients, acting as a container for aggressive and self-destructive behaviours, which over time lead to substantial clinical improvements. Outcome research from the Henderson Hospital demonstrated considerable cost-effectiveness when comparing

service usage among the PD patient group at pre- and post-treatment (Dolan *et al*. 1996). The average cost of a 1-year admission was recouped in the 2 years following treatment, identified from savings in health, prison, legal and social costs. Maden *et al*. (1994) also endorsed a psychotherapeutic community treatment approach with PD patients in the prison service.

A ground swell of support for therapeutic community (TC) approaches culminated in Sir John Reed's (1994) report. He highlighted that studies of therapeutic community treatments had shown the most promising results of any form of treatment for PD and psychopathy, in terms of psychological and behavioural changes during treatment, reduction of violent incidents in treatment settings and significant improvements following treatment. The 'Reed Report' helped to establish tenure for TC approaches in the repertoire of psychiatric services treating PD and provided a firm foothold for a new funding stream for TCs. The strength of evidence supporting TC's in the UK was mirrored in the USA. A growing body of TC outcome research led to a repositioning of TCs (or milieu therapy as it known in the USA) during the 1990s, as a major player in PD treatment in American correctional institutions (Wexler 1995). Martin *et al*. (1995) examined outcome data for 457 clients, 6 months following their release from a secure institution and found that the cohort who had participated in a TC had significantly lower rates of drug relapse and criminal recidivism than those offenders who had not been in a TC. Follow-up data collected at 6 and 18 months after entry into the 'Crest TC program' in Newark, likewise demonstrated that clients treated in the TC had significantly lower drug relapse and recidivism rates than the client control group (Nielsen *et al*. 1996). Hiller *et al*. (1999) gathered data from another large-sample group of 396 male inmates (293 treated, 103 untreated) in Texas and using a variety of measures (self, counsellor and peer ratings alongside state-maintained computerized criminal history records) showed that recidivism was lower among the TC-treated group than the non-treated cohort.

It has been noted that the effectiveness of a milieu or TC intervention was further enhanced by residential aftercare (Nielsen *et al*. 1996, Hiller *et al*. 1999, De Leon *et al*. 2000). The length of time a patient stayed in therapy was found to be a crucial factor in determining treatment success; the longer the time in therapy, the lower the rate of relapse or reoffending (Cullen 1997). Interestingly, Cullen (1997) suggested that when some patients dropped out early, they were considered worse than prior to treatment: that premature closure left the patient destabilized (deconstructed) before any process of reconstruction had begun. De Leon *et al*. (2000) argued that attention in TC research has yet to fully examine the process factors effecting treatment containment and retention. The task is understood to be one of providing a treatment milieu that offers the greatest level of containment and the lowest level of dropout, without compromising the stringent rigor of therapy.

Key worker or group therapy?

One feature of therapy that remains a constant in the flux of adapting TC or milieu therapy approaches is the central role of group-based approaches. Indeed, in some of the service provider commissioning questions (about what should be purchased with regard to treating PD), it is noteworthy that group approaches have endured in PD treatment, while other approaches have not. Group-based approaches may have emerged organically, from a social impulse in treatment that inherently counters the anti-social basis of the relational incapacity of PD patients.

Key worker systems are absent in many TCs, the emphasis instead is placed on co-operative responsibility. This is not to say that hierarchies in TCs have been compressed out of sight, with staff operating in a laissez-faire manner, without any clear governance structures. Rather, democratic operational structures in TCs have sought to devolve power as far as possible, maximizing the potential of patient–staff, patient–peer partnerships and a process of shared governance (Winship 1995, 1996, 2004). In contrast to an individual approach (e.g. of a key or caseworker), a hypothesis might be that a more collectively orientated intervention (to include patient peers, family and significant others) extends the containment of what constitutes a professional care team. There is a potential danger of a sustained focused transference (on a single person/key worker) which can be diminished when the therapeutic relationship is held in the context of a network of contacts. In this way, the multidisciplinary team collectively gather the range of the patient's projections and that this shared responsibility can be increased with peer systems of democratic engagement (Winship 2004). It may make administrative sense to locate bureaucratic responsibility with a key worker but, there should be concern of any command structure that aspires to singularize power, rather than dispersing it, this is the dialect of democracy vs. dictatorship. From an emotional point of view, it would seem naive to reduce the intensity of a particularly disturbed patient's contact into a focused exchange with any one person. This is particularly self-evident in the case of primary care worker roles, where there is an even greater possibility of dangerous transference through prolonged intensity of contact. The case load of a primary worker (key worker or registered medical officer) should attempt to avoid resembling the desperate plight of a single parent, trying to struggle on alone, within a neglectful social support system. A collective support network (of

a multidisciplinary team) may at best resemble a coherent extended family transference, where a network of friends and relations offer support alongside parents and siblings enlarging the scope of an orthodox transference schema (for example, doctor as dictatorial father and nurse as nurturing mother).

It is perhaps within this scope of 'therapeutic collectivism' that group-based approaches have survived, by some process of natural social selection, in all TCs regardless of cultural orientation (hierarchical or democratic, analytic or social). On the one hand, groups can be seen as a sure base for exerting hierarchical authority, drawing on the instinct of group members to gather together and submit to a higher authority. The status quo is invariably maintained in this way, as a gregarious atmosphere of social homeostasis pervades, where safety and compliance are ascendant. At the other end of the dialect, a group can offer the antithesis to submission because there is an inherent propensity towards enfranchisement and social justice (Winship 1998, 2000). The collective of the group can exercise its urge towards empowerment and agency; even the weakest (or more unwell) members of the group can be drawn along by this urge. These dynamics are as beneficial to staff functioning as patient's therapy (Hardy & Winship 1997, Winship & Hardy 1999). Oppression is superseded by a concerted sense of fair play, as the group exercises its voice and will to righteousness. These social democratic principles have been embedded in the predominant arc of group psychotherapy in the UK as it emerged from the Frankfurt School tradition, followed through in the post-Frankfurt work of Karl Mannheim, Norbert Elias and Micheal Foulkes (Winship 2003).

Groups have remained on a sure footing for over 60 years in the field of psychiatry as a vestibule for holding a tension between maintaining safe authority and encouraging maturational enfranchisement. This group-based capacity seems to have a particular relevance in the treatment of PD where the potential for high levels of violence (including self-violence) that pervade the treatment milieu can be well contained in a group situation (cf. Mishan & Bateman 1994). Malignant omnipotence and the destructive self-authority of PD can be replaced by a steady new synthesis of social authority. Cullen (1994) demonstrated how TC group-type intervention brings about significant reductions in anxiety, social introversion, hostility and negative attitudes to authority figures.

Safety in numbers: an audit of group therapy

It is not that groups are considered some sort of panacea of interpersonal harmony, quite the opposite in fact, they are often experienced as truculent, agitated and fractious; quite simply very difficult to bear for both patients and staff. And yet, the absence of violence within group therapy encounters, with acutely disturbed patients, is a particularly striking feature and one that is often overlooked. The notion that groups are safe havens for psychiatric patients' contravenes a belief that has been held for many years (particularly during the 1970s and 1980s) which said that acutely disturbed patients should be spared the high expressed emotion of a group crucible. Yet, colleagues from the Maudsley (Beatrice Stevens and the authors) carried out a retrospective analysis of approximately 20 000 h of formal group therapy on acute and intensive care inpatient wards (from 1970 to 1990), noting only one violent incident during this time span. The same audit process was repeated subsequently 1991–2000 (GW, Kay Longworth) in Berkshire and Broadmoor, where the total number of formal hours in group therapy was in the region of 40 000 h, with no further violent incidents. This statistic: one violent incident per 40 000 h of therapy is based on naturalistic career memoir and purposive sampling, and of course a number of methodological questions could be mounted to criticize the empirical generalizability of the figure. However, even if one was to argue that this observation is little more than a collective biography of five clinicians, it remains the case that a large number of TC practitioners believe in the effectiveness of group-based approaches. When considering the 1:40 000 statistic, more than a hypothetical case for the value of group approaches in TCs in managing the hostility and possible dangerousness of PD patients emerges. Extensive clinical experience warns that the most likely time on an acute ward for a violent incident is during medication or meal times. Group time, if it can be embedded into the schedule of a treatment milieu (whether this is in an inpatient unit, day hospital context or a specialist TC) can be shown to create the safest space for patients and staff in the day's timetable. A caveat remains though that group work is demanding, but that the benefits are high.

The need for safe cohesion in the treatment milieu has been continually recycled by the necessity of group intervention appealing to the inherent urges for social density and collective experience. This instinctive urge towards the potential of containing group intervention was recognized in a DOH (2003) document on structuring inpatient treatments:

> 4.49 The therapeutic value of effective ward community groups involving experienced staff (from all disciplines) should be considered as part of any therapeutic milieu. These groups have the potential to contain and anticipate disturbance, use the resource of other users and offer opportunities for reflection and insight.
>
> *The Mental Health Policy Implementation Guide for Adult In-Patient Care Provision* (DOH 2003: X)

Summary

People with a diagnosis of PD run the gamut of being engaged with a wide, complex network of professional services, which in turn can lead to high levels of negative patient and staff attitude that can pervade any treatment milieu (Lewis & Appleby 1988, Miller & Davenport 1996, Warren & Dolan 1996, NIMHE 2003a). Locally provided PD treatment regimes are often seen as fractured and expensive, with staff left feeling deskilled and undervalued (Woolley 2005). Therefore, an effective treatment strategy is one that recognizes the necessity of multi-professional collaboration and treatment continuity. The TC group-based approach, with its emphasis on examining a matrix of social relationships between patients and staff, seems best able to facilitate exploration of inherent staff tensions occurring in the division of clinical and custodial responsibilities, from which much can be learnt about treatment efficacy for PD. This approach is also highly favoured by service users (NIMHE 2003a). Therefore, approaching PD from a social imperative constructed from the best available knowledge of social functioning may help to counter the anti-social characteristics of PD.

National Institute for Mental Health in England (2003b) recommend the development of specialist multidisciplinary teams, who receive adequate organizational support and training for dealing with PD as posing 'significant distress or difficulty and present with complex problems' (NIMHE 2003b, p. 7). The clinical skills necessary to envisage and foster the most conducive milieu to treating PD might be described in terms of a clinical sociological perspective rather than a more familiar psychological therapy frame. The notion of a clinical sociology perspective moves into a realm of clinical practice that repositions the frame of reference from medical and biological imperatives to a discourse of the social mind. A challenge with PD treatment is to extend any containing social network away from the narrowness of individual psychological models of treatment which, in our experience, can create untenable levels of individual burden on individual staff members. The patient in the long run receives a better overall quality of care when each individual staff member feels less burdened. It may be that the once esteemed aspiration of 'autonomy' in psychiatric practice (especially for nurses and social workers who have often been given the task of being a key worker) is given over to the process of joint responsibility of patients with PD and, more contentiously, their peers.

We might consider this collaborative paradigm as a shift from autonomy to 'deutonomy' [*sic*] drawing upon peer-group resources, as well as neighbourhood, family and voluntary carer supports. There are a number of detailed descriptions of these democratically inclined practices with PD clients emerging from the work of Rapoport (1960), highlighting the way in which democratic values had become helpfully imbued in TC practice. Envisaging a discourse of clinical sociology expresses an underpinning assumption that might reconfigure practitioner preparation and the development of attuned curriculum. A distinctive new strand of applied practice, based on some of the social assumptions outlined above, would provide a type of PD network mechanism that would influence policy and therein inform the values debate among professionals which might be currently weighted towards medical models of understanding (Manning 2002). Deepening a social understanding of mental illness through the development of a clinical sociological view opens the potential for keeping the social mind at the centre of any frame of theory and practice needs. A collaborative and community-orientated approach avoids key workers becoming overburdened through engaging instead with a democratic approach to the therapeutic milieu.

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