Can deficits in social problem-solving in people with personality disorder be reversed?1

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Summary Research evidence is beginning to emerge that social problem-solving can improve the functioning of people with personality disorder. This approach is particularly important because it may be relatively easy to train healthcare workers to deliver this intervention. However, the costs and cost-effectiveness of social problem-solving need to be established if it is to be made more widely available.

Declaration of interest None.

Over the past 50 years findings from many experimental studies have established the effectiveness of pharmacological and psychosocial interventions for people with a range of mental health problems. In contrast, the evidence base for interventions for people with personality disorder remains poor. Most research into the impact of such interventions has focused on psychosocial treatment of borderline personality disorder. There is little evidence to guide the management of people with other forms of personality disorder. Even in relation to the borderline type, few high-quality trials have been conducted. A recent systematic review of psychological therapies for people with borderline personality disorder concluded that: ‘studies are too few and too small to inspire full confidence in their results’ (Binks et al, 2006). Residential treatments for people with personality disorder have been evaluated (Lees et al, 1999), but such services can inevitably only be offered to – and may only be suitable for – a minority of all those with this disorder.

CONSEQUENCES OF A WEAK EVIDENCE BASE

The relative absence of research into community-based interventions for people with personality disorder is matched by a paucity of services for such people (National Institute for Mental Health in England, 2003). Various reasons have been proposed to explain this state of affairs. It has been argued that interpersonal problems experienced by people with personality disorder make it unrewarding for healthcare professionals to work with this group (Hinshelwood, 1999). Previous surveys have demonstrated professional ambivalence to working with people with personality disorders: in a recent British study examining the views of general practitioners and psychiatrists about which patients should be referred for treatment in secondary care, general practitioners were less likely to state that people with anxiety, depression and most other mental disorders needed to be referred to secondary care than were psychiatrists; in contrast, psychiatrists were less likely than general practitioners to state that people with personality disorders should be referred to secondary care (Walker et al, 2005).

An alternative explanation for the reluctance of psychiatrists and other mental health professionals to work with people with personality disorders is that they feel that they are not equipped to provide these people with satisfactory treatment. With their focus on monitoring mental states, psychotropic medication and powers of compulsory treatment at times of crisis, general mental health services were certainly not designed to meet the needs of people with personality disorders. Although such people may be referred to psychotherapy services, the limited availability of this resource, together with the relative lack of evidence, means that healthcare workers may be reluctant to refer people with a primary diagnosis of personality disorder. Given this context, findings from a randomised trial of social problem-solving therapy for people with personality disorder by Huband et al (2007; this issue) in this month’s journal are to be welcomed.

†See pp. 307–313, this issue
points on the social functioning scale, and further research is needed to establish whether this intervention results in sustained improvements in social functioning that are clinically as well as statistically significant.

Nonetheless, findings from this trial are important for several reasons. First, it included people with a range of personality disorders: 41% met diagnostic criteria for borderline disorder, 40% for avoidant disorder, and 14% for antisocial disorder. Nearly all previous trials have focused exclusively on those with a primary diagnosis of borderline disorder. This trial, together with other recent studies, is therefore important in highlighting the potential impact of outpatient treatment for people with a range of other personality disorders (Emmelkamp et al, 2006).

The use of three sessions of psychoeducation prior to the delivery of the main intervention is another noteworthy aspect of this trial. Levels of drop-out from treatment services for people with personality disorder are notoriously high. As with previous studies, these data show that those with the greatest level of personality disturbance are those least likely to engage in treatment. Examining ways to increase retention is therefore important, and the psychoeducational approach used in this study has intuitive appeal. It is not possible to work out whether the use of psychoeducation prior to the delivery of social problem-solving made a difference to drop-out rates in this study, but this hypothesis is amenable to experimental evaluation and should be tested.

Concerns have rightly been expressed about the gap between the evidence base for psychosocial interventions for people with psychosis and the extent of their delivery (Rowlands, 2004). Financial constraints are the main factor responsible for this ‘therapy gap’, and new psychosocial interventions will need to demonstrate cost-effectiveness if they are to be implemented in clinical practice. This pilot study did not demonstrate statistically significant reductions in service utilisation, but an important trend towards reduced contact with emergency medical services was seen. These findings clearly provide a basis for further investigation of this potentially valuable intervention. Should such studies demonstrate the cost-effectiveness of social problem-solving, they would not only improve the evidence base for treatment of personality disorder, but they might also go some way towards challenging the ambivalence that some healthcare professionals continue to have about working with people with personality disorders.

**REFERENCES**


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Access the most recent version at DOI: 10.1192/bjp.bp.106.031179

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