

# Personality disorders in primary care

What do we know?

What can we do?

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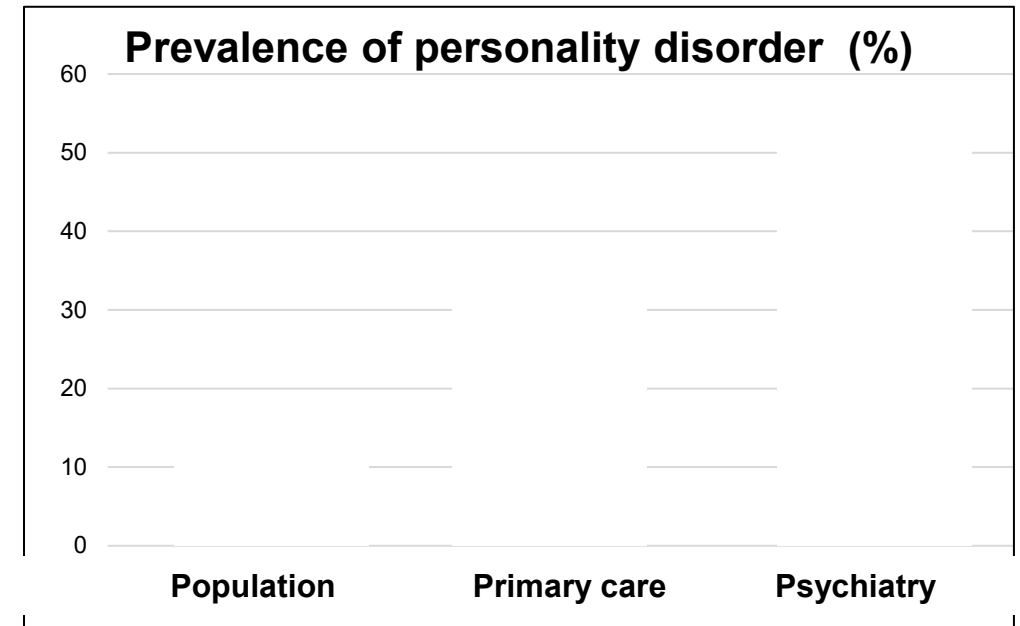
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# Prevalence

- Prevalence estimates in the general population range from 4% to 14.7% across studies<sup>1,6</sup>
- Primary care – very few studies
  1. London primary care study: ~24% prevalence<sup>2</sup>
  2. Swedish RCT in common mental disorders: 29.9% met criteria for personality disorder; most common were obsessive–compulsive (13.7%) and avoidant (12%)<sup>3</sup>
  3. Borderline personality disorder: estimated at ~6% in primary care<sup>7</sup>
- In psychiatric outpatient settings, the prevalence is approximately 50%.<sup>4,5</sup>



1. Torgersen S. *Scandinavian journal of psychology* 2009; **50**(6): 624-32.

2. Moran P et al. *Acta Psychiatr Scand* 2000; **102**(1): 52-7.

3. Ejeby, K. (2017). Doctoral thesis, Karolinska Institutet, Stockholm.

4. Beckwith et al. (2014). *Personal Ment Health*, **8**(2), 91-101. doi:10.1002/pmh.1252

5. Ekselius L. Personlighetsyndrom - kliniska riktlinjer för utredning och behandling. Svenska Psykiatriska föreningen, 2017.

6. Shadid J et al. *The Lancet Psychiatry* 2025; **12**(12): 932-46.

7. Dubovsky et al. *The Medical clinics of North America* 2014; **98**(5): 1049-64.



## Diagnos

## Prevalens i befolkningen över 18<sup>1</sup>

Personality disorder	5-10,5% <sup>1,3</sup>
Specific phobia	6-9 %
Alcohol use disorders <sup>2</sup> (Sweden)	8 %
Depression	5-7 %
Social anxiety disorder	2-7%
Panic disorder	2-3%
Generalized anxiety disorder	3 %
ADHD	2,5 %
Bipolar disorder	1,8 %
PTSD (Europe)	1%
Autism spectrum disorder	1 %
Disorders of intellectual development	1%
Tic disorders (in school age)	0,3-0,8 %
Schizofrenia	0,3-0,7 %
Delusional disorder	0,2 %


1. Kupfer DJ, Regier DA. Diagnostic and statistical manual of mental disorders: DSM-5. – 5th ed. Arlington, VA, USA.: American Psychiatric Association; 2013.
2. Larsson G. Bättre insatser vid missbruk och beroende - Individerna, kunskaperna och ansvaret. Stockholm: Regeringskansliet, 2011
3. Shadid J et al. *The Lancet Psychiatry* 2025; **12**(12): 932-46.

# Treatment

- Summary of outpatient treatments<sup>1</sup>
- Most were delivered by specialized teams or within specialist psychiatric outpatient care
- Many different interventions: CBT, DBT, MBT, psychodynamic therapy, and less common therapy formats
- Most often compared with waiting list or “treatment as usual”
- All showed good and comparable effects

1. Katakis et al. *BMC Psychiatry* 2023; **23**(1): 5

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## Effectiveness of outpatient and community treatments for people with a diagnosis of ‘personality disorder’: systematic review and meta-analysis

Panos Katakis<sup>1\*</sup>, Merle Schlieff<sup>2</sup>, Phoebe Barnett<sup>2,3</sup>, Luke Sheridan Rains<sup>2</sup>, Sarah Rowe<sup>1</sup>, Steve Pilling<sup>3,4,5</sup> and Sonia Johnson<sup>2,5</sup>

**Abstract**

**Background** Quality of care and access to effective interventions have been widely criticised as limited for people diagnosed with ‘personality disorder’ or who have comparable needs (described in some recent papers as “Complex Emotional Needs” (CEN). It is important to identify effective interventions and the optimal context and mode of delivery for people with CEN. We aimed to investigate the effectiveness of psychosocial interventions delivered in community and outpatient settings in treating symptoms associated with ‘personality disorder’, and the moderating effects of treatment-related variables.

**Methods** We systematically searched MEDLINE, EMBASE, PsycINFO, CINAHL, HMC, ASSIA for articles published in English, from inception to November 23, 2020. We included randomized controlled trials examining interventions provided in community or outpatient settings for CEN. The primary outcome was ‘personality disorder’ symptoms, while secondary outcomes included anxiety symptoms, depressive symptoms, and global psychiatric symptoms. Random-effects meta-analysis was conducted for each outcome, and meta-regression analysis was performed to assess the moderating effects of treatment characteristics. The quality of the studies and the degree of publication bias was assessed.

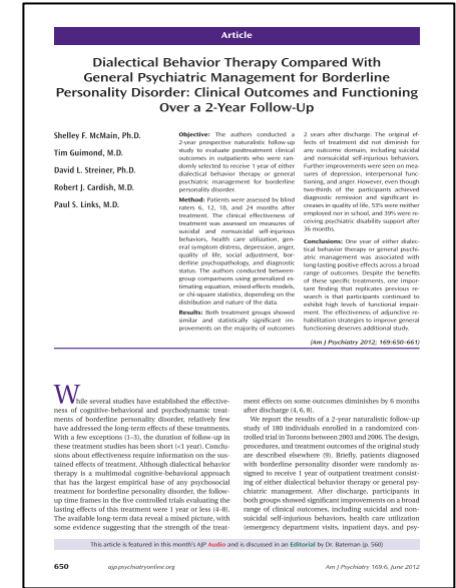
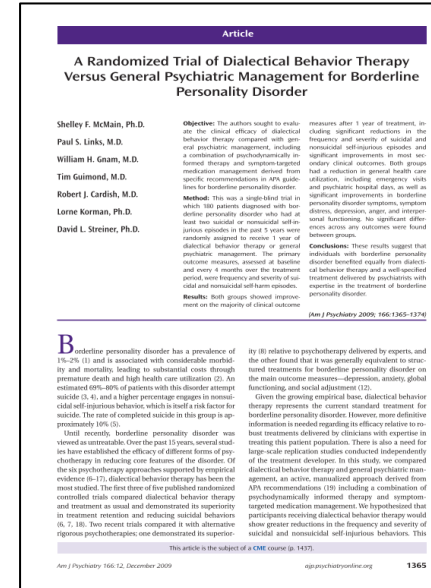
**Results** We included 54 trials ( $n = 3716$  participants) in the meta-analysis. We found a large effect size ( $g = 0.78$ , 95% CI: 0.56 to 1.01,  $p < 0.0001$ ) favoring interventions for ‘borderline personality disorder’ (BPD) symptoms over Treatment as Usual or Waitlist (TAU/WL), and the efficacy was maintained at follow-up ( $g = 1.01$ , 95% CI: 0.37 to 1.65,  $p = 0.002$ ). Interventions effectively reduced anxiety symptoms ( $g = 0.58$ , 95% CI: 0.21 to 0.95,  $p = 0.002$ ), depressive symptoms ( $g = 0.57$ , 95% CI: 0.32 to 0.83,  $p < 0.0001$ ), and global psychiatric symptoms ( $g = 0.50$ , 95% CI: 0.35 to 0.66,  $p < 0.0001$ ) compared to TAU/WL. The intervention types were equally effective in treating all symptom categories assessed. Treatment duration and treatment intensity did not moderate the effectiveness of the interventions for any outcome.

**Conclusions** People with a ‘personality disorder’ diagnosis benefited from psychological and psychosocial interventions delivered in community or outpatient settings, with all therapeutic approaches showing similar effectiveness.



# Good Psychiatric Management (GPM)

- Shows that GPM ≈ DBT in effectiveness on key outcomes for borderline personality disorder (e.g., self-harm)<sup>1,2</sup>
- Why is GPM of interest for primary care?
  - Aligns with the tradition of generalist models that have shown comparable effectiveness in other studies
  - Does not require specialized expertise
  - Can be taught in a shorter training
  - Builds on knowledge that healthcare staff already have



- McMain SF et al. *The American journal of psychiatry* 2009; **166**(12): 1365-74.
- McMain SF et al. *The American journal of psychiatry* 2012; **169**(6): 650-61.



## Problems related to personality disorder in primary care in Sweden




# Stepped care approach

