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Psychotherapy for Personality Disorders: Questions of Clinical Utility

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Patients with personality disorders (PDs) represent a particular burden for the health system and the clinicians attempting to treat them. The current commentary complements reviews of outcome studies on treatments for PDs by focusing on the clinical utility as defined by the American Psychological Association. As such, extending that notion, clinical utility of a treatment comprises aspects of implementation and training in the model as well as qualities of the therapeutic technique and relationship. Our review suggests that a certain caution needs to be applied when reading outcome studies based on specific methodological caveats. In specific contexts, inpatient and day hospital treatments have some initial appeal in reducing symptoms, in particular for the treatment of more severe forms of Cluster A and B PDs. In general, treatments for PDs are long-term treatments, administered in rather high dosage, which tends to be true irrespective of the treatment model. For specific treatment targets, there is emerging evidence on effectiveness of short-term interventions. The therapeutic relationship with patients with PDs may be characterized by strains and interactional difficulties that may be addressed using clinically adapted treatment strategies. To be effective, therapists should have an open-minded and flexible approach to therapy, which is particularly central from an integrative perspective. Finally, we state that a key element for implementation of an effective treatment model is a manual-based training that, albeit controversial, remains a key component allowing for the trainee therapist to self-monitor his or her progress and get specific help in supervision as part of the learning process. We advocate that clinicians and administrators should consider these points as being specifically related with clinical utility of treatments for PDs because they contribute to optimize the implementation process of a therapy approach to a specific context.

Keywords: personality disorders, effectiveness, clinical utility, psychotherapy

Clinicians tend to find the therapeutic work with patients presenting with personality disorders (PDs) challenging and, for some, unrewarding (Lewis & Appleby, 1988; Paris, 2007). Patients with PDs are known to present with several interaction and regulation problems (Bender & Skodol, 2007; Gunderson & Links, 2008; Gunderson & Lyons-Ruth, 2008;

Paris, 2007) that may provoke in therapists, among others, negative reactions, emotional retreat, or feelings of helplessness (Lewis & Appleby, 1988). PDs are also associated with a high societal burden of disease (Soeteman, Verheul, & Busschbach, 2008), along with individual suffering in terms of diminished quality of life on part of the patients, their families, and sometimes their clinicians. As such, despite accumulating outcome research (Budge et al., 2013), some therapists in regular practice may continue to deliver suboptimal treatments for patients with PDs. Therefore it is necessary to bridge the gap between the results from outcome research (i.e., randomized controlled trials and meta-analyses) on the one hand and current clinical practice on the other. What is the actual clinical utility of different kinds of psychotherapy of PDs?

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In the present paper we will address this question in a synthetic fashion for clinicians and administrators interested in implementing concrete treatment programs in their communities. Answering this question might be particularly important from a psychotherapy integration perspective (Clarkin, Cain, & Livesley, 2015; Dimaggio, 2015; Livesley, Dimaggio, & Clarkin, 2016; Paris, 2015). In doing so we will elaborate on specific questions related to clinical utility, implementation, and optimal dosage of treatment (American Psychological Association [APA], 2002). Clinical utility of a treatment was defined by the APA (2002, p. 1052) as “applicability, feasibility, and usefulness of the intervention in the local or specific setting where it is to be offered.” Beyond this general definition, clinical utility also includes questions of dosage, generalizability of a treatment for which efficacy has been demonstrated, cost-effectiveness, and ease of implementation. It is also important to consider the ethical aspects of new psychotherapeutic treatments: liability and risk management are central in this regard. We aim to address three potential problems when implementing a therapy approach for patients with PDs as nonexhaustive examples of questions related to clinical utility of psychological treatments. (a) Is the methodological basis of the initial studies sound? (b) Which specificities of the context of implementation are there, requiring adaptations of outpatient treatment to partial hospitalization, inpatient treatment, or short-term intervention? (c) Which are active ingredients in treatments for PDs, in particular from an integrative perspective? If these problems are addressed, then the clinical utility of a specific treatment should be optimized in a specific context. Our reflections aim at a general statement for all PDs; however, it might be ideal to formulate these problems and implications for each PD category separately given their high heterogeneity.

Methodological Basis of Outcome Studies for PDs

The question of outcome has been addressed by six meta-analyses focusing on psychological treatments thus far, out of which three focused on PDs in general (Budge et al., 2013; Leichsenring & Leibing, 2003; Perry, Banon, & Ianni, 1999) and three on borderline personality

disorder (BPD) in particular (e.g., Binks et al., 2006; Stoffers et al., 2012); several treatment recommendations were also published (e.g., American Psychiatric Association, 2001; Gaebel & Falkai, 2009; Hadjipavlou & Ogradniczuk, 2010; Leichsenring & Rabung, 2011; Sanislow & McGlashan, 1998; Verheul & Herbrink, 2007).

Whereas 20 years ago there were hardly any researched treatment models specifically adapted to the treatment of PDs, leaving the clinician alone with this challenging group of patients, today we are in the position of recommending the use of several treatment models that have shown effectiveness in the treatment of PDs.

The first question we would like to answer relates to absolute efficacy of treatments for which several studies exist; in particular for BPD there is also some evidence for narcissistic and dependent PDs. In the most recent meta-analysis, Budge and colleagues (2013) have compiled and analyzed 30 studies that compared an active psychotherapeutic treatment with treatment as usual. All of these studies were published in the last 24 years; as such, it represents the most comprehensive review to date. They have shown that active psychotherapeutic treatments are more efficient than a minimal treatment as usual with medium effect size ($d = .40$). Treatment as usual is defined here as minimal intervention strategies—not psychotherapy, but any form of psychiatric standard care. We note that those structured, bona fide, psychotherapy models present with at least six generic characteristics which may, or may not, contribute to their effectiveness: (a) a clear rationale or underlying theory of functioning of a patient presenting with PD; (b) a clear rationale for implementing structured treatment or predictions related to which therapeutic actions would foster symptom alleviation; (c) specific therapeutic procedures and techniques to be implemented; (d) specific, for the most part manual-based, training modules for interested therapists to learn the model; (e) a particularly active therapist stance; and (f) a particular focus on the building of the therapeutic relationship.

Among the ones most often studied, one can find the efficacious treatments for BPD, which are dialectical-behavior therapy (e.g., Bohus et al., 2004; Linehan, 1993; Linehan et al., 2006; McMain et al., 2009; Pasieczny & Connor,

2011; Pistorello, Fruzzetti, Maclane, Gallop, & Iverson, 2012; Priebe et al., 2012; Soler et al., 2009; van den Bosch, Verheul, Schippers, & van den Brink, 2002), transference-focused psychotherapy (TFP; Clarkin, Levy, Lenzenweger, & Kernberg, 2007; Doering et al., 2010; Giesen-Bloo et al., 2006), mentalization-based treatment (Bateman & Fonagy, 1999, 2008), schema-focused therapy (Bamelis, Evers, Spinhoven, & Arntz, 2014; Farrell, Shaw, & Webber 2009; Giesen-Bloo et al., 2006; Jacob et al., 2010), and systems training for emotional predictability and problem-solving (Blum et al., 2008).

In addition to these, there are several potentially effective treatments for PDs that are alternative options for clinicians, but with more limited empirical bases, such as cognitive (Cottraux et al., 2009; Davidson et al., 2009; Emelkamp et al., 2006), psychodynamic (Høglend et al., 2011; Svartberg, Stiles, & Seltzer, 2004), humanistic-experiential (Pos & Greenberg, 2012; Pos, 2014; Sachse, Sachse, & Fasbender, 2011), dynamic-deconstructive (Gregory, DeLucia-Deranja, & Mogle, 2010), and interpersonal (Benjamin, 1993; Dimaggio, Semerari, Carcione, Nicolo, & Procacci, 2007) psychotherapies. All represent specific adaptations to the requirements of patients with PD. Even if not all have presented with empirical evidence, it can be postulated that they represent potentially valid treatment options for PD, to various extents, when compared with a minimum standard care. Some of these treatment models have been tested under “real” practice conditions, using effectiveness or naturalistic designs or other means (e.g., by formulating minimal exclusion criteria maintaining natural variability of the included patients) increasing the external validity of the trial, which is an argument favoring their clinical utility for a specific clinical context.

A particularly important question for clinical utility is the observation that certain outcome studies seem to demonstrate “superiority” of a particular treatment approach over another active treatment. Does this mean that certain treatments are most effective and should be chosen for implementation? We argue, with Budge and colleagues, that these between-condition effects may be attributable to several methodological problems of the initial studies, including the researcher’s allegiance. Researcher’s allegiance

is well described as one of the most influential effects on results in efficacy studies (Luborsky et al., 1999) and denotes the preference of a research team who conducts a study for a specific treatment model (and thus a nonpreference for the alternative treatment model). We may add that another characteristic of an outcome study is the quality of ratings of the main outcome variable: raters who are nonblind to the treatment condition (i.e., who know the condition a specific patient is in) tend to report higher between-groups effects when compared with blind raters unknowledgeable of the treatment condition. Finally, differences in therapist adherence—the degree to which therapists actually do what the manual prescribes (and hold back from doing what the manual prohibits)—may be another source for differences found between active treatments. For these reasons, there might here and there be an individual study that reports between-condition effects for two active treatments: these results should be interpreted with great caution. Similar comments may be true for studies on efficacy for medication. In the domain of psychotherapy for PDs, Giesen-Bloo and colleagues (2006) have found differences in the efficacy between two effective long-term treatments, TFP, and schema-focused psychotherapy, favoring the latter. With regard to this study, Yeomans (2007) highlighted possible problems with therapist adherence in the TFP condition whereas Levy, Meehan, and Yeomans (2012, p. 145) discussed one of the “most potent methodological choices that results in allegiance effects”: the preselection of therapists who differ in skillfulness favoring the condition preferred by the researchers. When taking into account all of these possible influences and when adequately interpreting findings of the literature as a whole, one can conclude, with some caution, that active and PD-specific treatments tend to be equally effective. It is important to note that not all treatments present evidence for all categories of PDs—in fact, to our knowledge, no treatment presents evidence for all *Diagnostic and Statistical Manual of Mental Disorders* (fifth edition; *DSM-5*) PD categories: this does not mean they are ineffective for specific understudied forms of PDs. Therefore, all PD-specific bona fide treatments merit to be implemented when done by skillful therapists. Skillfulness may be assured by sufficiently intense training of the ther-

apists, which involves for patients with PD case supervision based on tape-reviewing of the actual patient-therapist interaction. Manuals that were developed may also facilitate the self-monitoring by the therapists themselves, complementing individual case supervision.

Specificities Related to Context of Implementation

In certain countries and contexts, partial hospitalization and inpatient treatments are favored. Should treatments for PDs be used in these contexts?

Partial hospitalization, or day hospital treatment, involves structured day activities over a period of time during which the patient spends the evenings and nights elsewhere. A recent clinical review and recommendation (Verheul & Herbrink, 2007) suggests, taking the empirical literature together, that Cluster A (with some severe forms of Cluster B) PDs respond well to long-term day hospital treatment whereas Cluster C and the remaining (less severe forms of) Cluster B PDs benefit rather from short-term treatment frames. It is advised that partial hospitalization is optimally followed by an outpatient psychotherapy treatment program that helps to deepen and generalize the effects of the initial day hospital treatment (Gunderson & Links, 2008; Verheul & Herbrink, 2007). Inpatient treatment of PDs generally represents long-term psychodynamically informed milieu-based treatment involving 6–12 months of hospitalization. Such intervention tends to be effective for any PDs (see the review by Verheul & Herbrink, 2007). Shorter, multimodal, and specifically intense treatment frames have also shown their effectiveness (e.g., Sollberger et al., 2014). Similar to the day-hospital option, it is generally advised to plan a follow-up outpatient psychotherapy program after an inpatient treatment for PDs.

When implementing a specific treatment approach in a community, the question of dosage is central. For how long and how intense should the treatment be? Based on four outpatient studies at the time, the meta-analysis by Perry and colleagues (1999) estimated that 25% of patients with PD recovered after 5 months of treatment, 50% after 15 months (equivalent to 90 sessions), and 75% after 26 months (encompassing more than 200 therapy sessions). Such

progression over time is slightly smaller than found in other patients and as described in the seminal contribution by Howard, Kopta, Krause, and Orlinsky (1986). The latter describes a negatively accelerated curve when relating dosage to therapy outcome over time. It needs to be noted that without appropriate controls, dose-effect relationships may not be attributable to the specific treatment approach but may be the result of a spontaneous remission. Leichsenring and Rabung (2011) have reported that the rate of recovery for PDs might differ between therapy approaches, with an optimum of approximately 100 sessions for psychodynamic psychotherapies for PD to be effective, which might be shorter for cognitive therapies, although it is not clear if the detailed quality of recovery is comparable between these treatment approaches. In addition, several authors recommend highly intense treatments; for example, twice-weekly outpatient psychotherapy (e.g., Yeomans, Clarkin, & Kernberg, 2002) or intense multimodal inpatient treatment (Gaebel & Falkai, 2009). Thus far, these considerations on dosage include quite different forms of therapy and do not specify the severity of patients at intake. Researchers have demonstrated for specific target symptoms short-term changes across treatment models: first effects were observed after 3–6 months of treatment for patients with BPD (Blum et al., 2008; Kramer et al., 2014; Palmer et al., 2006; Stanley, Brodsky, Nelson, & Dulit, 2007). Therefore, more studies are necessary on treatment dosage to determine optimal levels of care for each PD.

Effective Ingredients: The Therapist and the Therapeutic Relationship

Although the specific technique matters very little, as shown by several psychotherapy studies (see Budge et al., 2013), research has suggested the relevance of the so-called common factors in psychotherapy (e.g., empathy, therapeutic alliance, group cohesiveness; Smith, Barrett, Benjamin, & Barber, 2006; Wampold, 2001). There are several caveats when treating patients with PD. First, it needs to be noted that, maybe contrary to clinical intuition, the therapeutic alliance in treatments for patients with BPD tends to be only weakly related with the therapeutic outcome at the end of treatment according to a recent meta-analysis (Scala, El-

lison, & Levy, 2014). Second, the common factor concept does not specify concretely how the therapist should go about facilitating such common processes in the therapy room (Stiles, 2013). Third, it might be particularly difficult for a therapist facing a patient with PD to implement such common factors related to the challenging moment-by-moment interpersonal and intrapsychological fluctuations of mental states observed in these patients (Levy, Beeney, Wasserman, & Clarkin, 2010).

There are specific clinical procedures facilitating the increase of the quality of the collaboration that are adapted to the requirements of patients with PDs and take into account the aforementioned problems (McMain, Boritz, & Leybman, 2015). For example, for BPD it was shown that when the therapist is responsive to behavior-underlying motives, there is additional symptom alleviation in the initial sessions of therapy for BPD (Kramer, Flückiger, et al., 2014; Kramer, Kolly, et al., 2014). For Cluster B and C PDs, it was shown that a focus on the reparation of strains and ruptures in the therapeutic alliance was related with increased symptom alleviation in psychotherapy (Muran, Safran, Wallner Samstag, & Winston, 2005); such alliance ruptures were rated higher by patients presenting with features of impulsivity, dysregulation, and lability (Tufekcioglu, Muran, Safran, & Winston, 2013) compared with patients without these characteristics. These results call for more sophisticated and complex conceptions of the therapeutic interaction and relationship, the collaboration, patient engagement, and the therapeutic alliance in treatments for PDs.

The person of the therapist is, last but not least, central in the treatment with patients presenting with PDs. It is noteworthy that most trials that have studied treatments for PDs did not take into account the therapist variable, although a large literature exists on the moderating effect of the therapist on outcome (Baldwin & Imel, 2013). From a clinical perspective, Fernandez-Alvarez, Clarkin, Salgueiro, and Critchfield (2006, p. 215) have summarized that the effective therapist facing a patient with PD should (a) be open-minded, flexible, and creative in the treatment approach; (b) be comfortable with long-term treatments requiring emotionally intense relationships; (c) be tolerant of his or her own negative affects; (d) have pa-

tiency; and (e) have a specific training in the treatment of PDs. Therefore, the therapist needs specific skills to manage his or her own inner (i.e., countertransferential) reactions to the interactions with these patients to be able to effectively intervene (Livesley et al., 2016). We believe that this can be achieved, again, by thorough training in the clinical models and procedures. If training seems important, then accurate research on if training has the expected impact of the quality of intervention facing patients with PDs is still lacking. Recently, Keuroghlian and colleagues (2015) have published a report on a 1-day introductory class into psychiatric treatment for patients with BPD. After this brief exposure did the participants report more hopefulness in the treatment of these patients and increased levels of trust in their therapeutic skills. Furthermore, their image of these patients had changed toward a more nuanced view of a person with low self-esteem in need of care. More research is definitely needed on the effect of training for the quality of intervention facing these patients, in particular long term training programs.

Conclusions

Clinical utility of a treatment refers to its implementation and generalizability to different contexts of care, including in our view questions of quality of training, quality of intervention, dosage, and the adaptation to specific settings. Because outcome research tends to suggest that no specific model imposes itself as the most effective, clinical utility of the model to be implemented refers to dynamically changing contextual variables. Therefore, the success of such a therapy, given these contextual variables, might not necessarily depend on the specific underlying theory nor on the specific therapeutic techniques but rather on the quality of the therapeutic relationship the therapists and patients succeed to develop on a moment-by-moment and session-by-session basis, along with therapist characteristics in effectively dealing with the typical interaction problems presented by these patients. Therefore, integrative practice, and training therein, may focus on the use of therapist skills in elaborating treatment contracts (Yeomans et al., 2002), identify problems in the actual therapeutic relationship and discuss and amend them (Tufekcioglu et al.,

2013), and offer specific individualized interventions tailored to each patient (Kramer et al., 2014) and the use of short-term intervention modules that are readily implemented (e.g., Stanley et al., 2007). A remaining challenge is the formulation of specific caveats of treatments for all PD categories; for example, it might pose different problems to implement a therapy form for avoidant PD or BPD.

When implementing a therapy approach in the community—a necessary stepping stone between state-of-the-art outcome research and the actual clinical reality—it is necessary to take into account the clinical utility and its implications. Providing therapy training in a community context is not sufficient per se. We think it should be done a specific way by closely monitoring the therapist adherence incorporating feedback over time along with a specific focus on therapist and relationship variables as they unfold in the interaction with the patient.

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