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Psychotherapy for Personality Disorders

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Synonyms

Axis II; Personality; Psychotherapy; Therapy; Treatment

Definition

Psychotherapy for personality disorders – a group of disorders characterized by long-standing patterns of intra- and interpersonal difficulties – tends to be highly structured, integrative, and often long-term, with special attention made to the relationship between therapist and patient.

Introduction

Personality disorders (PDs) are a heterogeneous group of mental disorders that arise when an individual's personality is considered impaired and maladaptive. Most definitions of personality disorders stress the chronic, long-standing nature of characteristics and patterns of responding to distress that often are limited in variability and rigidly applied regardless of appropriateness to context (Levy and Johnson 2016). In the latest editions of both the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*) and the *International Classification of Diseases* (ICD-10), PDs are described as a pattern of inner experience and behavior that deviates from cultural norms and involves impairments in a number of domains, such as emotional and interpersonal. The *DSM-5* describes ten specific personality disorders: Cluster A (odd, eccentric) paranoid, schizoid, and schizotypal PDs; Cluster B (dramatic, emotional, erratic) antisocial, borderline, histrionic, and narcissistic PDs; and Cluster C (anxious, fearful) avoidant, dependent, and obsessive-compulsive PDs. The *ICD-10* echoes these disorders with the exception of schizotypal and narcissistic PD. Both the *DSM-5* and *ICD-10* also include categories for other specified personality disorder and unspecified personality disorder.

PDs are highly prevalent in the general population (likely around 10%, with some estimates of up to 18%). Epidemiological data in the United States indicate that PDs have a high overall lifetime prevalence ranging between 5.9% and 21.5% in the community, with most estimates ranging between 9% and 11% (Levy and Johnson 2016). International epidemiological studies find similar rates ranging from 4.4% to 13.4%, depending on whether PD not otherwise specified (PDNOS) was included (Levy and Johnson 2016).

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There are almost no community data on PDs from countries other than the United States, the United Kingdom, Germany, Norway, and Australia.

In primary care settings, about a third of people meet the criteria for a PD, although this is not usually the presenting concern (Levy and Johnson 2016). Patients with Cluster C PDs are the most common PDs to be encountered in primary care settings. Rates of PDs are generally much higher in clinical populations. Studies using structured diagnostic assessments have found that 20–40% of psychiatric outpatients and about 50% of psychiatric inpatients meet the criteria for a PD (Levy and Johnson 2016).

In addition to being prevalent, PDs are often overlooked sources of social cost, family burden, risk for comorbid physical and psychological conditions, and morbidity and mortality. PDs are associated with frequent, erratic, and prolonged psychiatric and emergency medical care, as well as increased usage of longer-term treatment, contributing to significant burden on the healthcare system and added healthcare costs. PDs also place burden on families of individuals with the diagnosis in terms of depression, anxiety, hostility, and other psychological symptoms, over and above that contributed to by other disorders. The presence of a comorbid PD may also complicate and prolong treatment for other psychiatric conditions. These burdens – on society, families, and the individual with the disorder – mandate effective and timely treatment for these individuals. In fact, although it is not conclusive, evidence suggests that current treatments for PDs may be able to reduce the costs of these disorders by up to a third.

Treatment

Treating PDs has traditionally been thought to be difficult, time-consuming, and generally ineffective. BPD, for instance, the most studied of the PDs, has long garnered aversion from practitioners, in part due to treatment reticence and regression in unstructured treatments such as traditional psychoanalysis. Furthermore, individuals with personality pathology often generate negative reactions in their therapists directly, presenting with extreme dependence, hostility, or confusing vacillation. In part for these reasons, research on PD treatments has lagged far behind that for other psychological disorders. However, as outlined below, a number of specific treatments for PDs (focused predominantly on BPD) have been developed and have shown surprising efficacy.

Several meta-analyses provide encouraging findings regarding the effectiveness of psychotherapy for PDs in general (Budge et al. 2013; Leichsenring and Leibing 2003; Perry et al. 1999). Perry et al. (1999) identified 15 studies, including 6 randomized controlled trials (RCTs), and found large pre- to posttreatment effects, with longer treatments yielding greater change. Their findings indicated that psychotherapy is not only an effective treatment for PDs but produced a seven times faster rate of recovery than natural remission. A second meta-analysis (Leichsenring and Leibing 2003) examined the efficacy of both psychodynamic therapy (PDT) (14 studies) and cognitive behavioral therapy (CBT) (11 studies) in the treatment of patients with PDs; 11 of the studies were RCTs. The authors reported pre- to posttreatment effect sizes using the longest-term follow-up data reported in the studies. For PDT (mean length of treatment was 37 weeks), the mean follow-up period was 1.5 years after treatment end, and the pre- to posttreatment effect size was very large ($d = 1.46$) indicating that psychodynamic treatment benefits endure over time. For CBT (mean length of treatment was 16 weeks), the mean follow-up period was 13 weeks, and the pretreatment to posttreatment effect size was large ($d = 1.0$). The authors concluded that both PDT and CBT demonstrated effectiveness for patients with PDs but that current evidence for long-term effectiveness is stronger for psychodynamic psychotherapy. The most recent and comprehensive meta-analysis on PDs (Budge et al. 2013) analyzed 30 studies that compared an active psychotherapeutic treatment with treatment-as-usual, finding that active psychotherapeutic treatments were more efficient than treatment-as-usual comparisons, with a medium effect size ($d = 0.4$). In addition, the effectiveness of PDT for individuals

with PDs is supported by recent meta-analytic studies for short-term PDT (e.g., Barber et al. 2013). Findings from these meta-analyses suggest that psychodynamic and cognitive behavioral treatments for PDs are far more effective than no treatment, are modestly more effective than treatment-as-usual, and appear to be comparable in efficacy.

However, findings from these meta-analyses of PDs are difficult to interpret because of the mixing of different disorders both within studies included in meta-analyses and within and between meta-analyses. The different PDs vary in terms of severity and dynamics. When grouped together in treatment studies, it becomes unclear which personality disorders or what dynamics are driving the effects. For example, those with Cluster C, anxious-fearful PDs, tend to be less disturbed than those with Cluster B PDs and can be very compliant in treatment and even acquiescent. In contrast, those with Cluster B, dramatic and emotional PDs, may display high levels of affect or experience conflict with the therapist in treatment. Although identifying common treatment recommendations across the range of PDs can be quite useful, as we attempt below, further research on specific PDs would add utility to the current body of research, particularly when control groups are better accounted for. To date, most of the psychotherapy studies have been with patients suffering from BPD, ASPD, and mixed Cluster C personality disorders. There have been no controlled or uncontrolled outcome studies for histrionic, dependent, schizotypal, schizoid, narcissistic, passive-aggressive, or paranoid PDs.

Cluster A PD Treatments

Research on psychotherapy for the treatment of Cluster A (paranoid, schizotypal, and schizoid) PDs has been fairly limited, perhaps because such patients may be less likely to present for treatment. Research from naturalistic follow-up studies of hospitalized patients suggests that patients with Cluster A PDs do not show much improvement over time. However, a few trials have found that patients with mixed Cluster A PDs improved significantly following psychotherapy. One study found that patients in day hospital and inpatient conditions experienced greater improvement than patients in an outpatient treatment condition (Bartak et al. 2011) suggesting that more intensive approaches may be helpful for patients with Cluster A PDs.

Cluster B PD Treatments

Within Cluster B PDs, most treatment studies have focused on BPD. A few have examined psychotherapy for mixed Cluster B patients. In an uncontrolled study of 207 patients with a Cluster B PD (77% BPD), Bartak et al. (2011) found improvements up to 18 months after initial assessment in symptoms, functioning, and well-being across outpatient, day hospital, and inpatient treatments. The treatments were conducted as standard care in the Netherlands, and the hospital-based treatments tended to include both group and individual psychotherapy. Inpatient treatment trended toward greater effectiveness than the other treatments, although this trend may have been driven by higher baseline symptoms among the inpatient-admitted patients. Two other psychodynamically influenced inpatient therapies have also been shown to be effective for Cluster B patients in comparison to controls either on a waitlist or receiving treatment-as-usual (TAU; Leichsenring et al. 2016), consistent with findings above of the effectiveness of inpatient therapies for this group of disorders.

Borderline Personality Disorder. The majority of psychotherapy outcome research for Cluster B PDs has focused on BPD. There is evidence of varying degrees of support for at least nine therapies for this disorder, derived from a range of psychotherapy orientations. These treatments include the following individual psychotherapies (some with additional group-based components) from a cognitive behavioral tradition: dialectical behavior therapy (DBT), schema-focused therapy (SFT), and standard CBT, and the following from a psychodynamic tradition, mentalization-based treatment (MBT), transference-focused psychotherapy (TFP), dynamic deconstructive psychotherapy (DDP), and cognitive analytic therapy (CAT). Of these, DBT, MBT, TFP, and SFT have received the most research and empirical support, and a recent meta-analysis suggests that DBT and

the psychodynamic treatments (i.e., MBT, TFP) consistently show improvements over and above control conditions (Cristea et al. 2017).

Although these treatments tend to derive from either CBT or PDT traditions, they tend to be similarly structured and highly integrative, either implicitly or explicitly. For example, although SFT was developed by Jeff Young, influenced significantly by Aaron Beck, the treatment explicitly integrates psychodynamic attachment theory and object-relations-theory-based conceptualizations and techniques. Likewise, CAT originated in the psychoanalytic tradition, with an explicit focus on the "existential realities and complex difficulties of human life," a characteristic focus of PDT, and grew out of object relations theory specifically, yet incorporated the operationalizability of explicit cognitive views of the self (known as "self-states") and the characteristically CBT technique of assigning homework. Similarly, although DBT is conceptualized primarily from a behavioral perspective, using behavioral principles and language, Marsha Linehan, the developer of DBT, took a sabbatical with the psychoanalysts Otto Kernberg and John Clarkin in the mid-1980s as she was early in the development of DBT and DBT reflects influences of the psychodynamic school of thought on BPD (e.g., integration of disparate aspects of the self in "Wise Mind").

Dialectical Behavior Therapy. Developed by Linehan in the late 1980s, DBT evolved from CBT as a treatment program for women with parasuicidal and suicidal behaviors. As this group of behaviors is one of the defining symptoms of patients with BPD, DBT soon began to be tested as a treatment for individuals with this disorder. As traditional CBT was deemed inefficacious for self-injury and personality pathology, Linehan identified behavioral techniques and skills training to alleviate behavioral manifestations of emotion dysregulation in BPD as well as improve interpersonal functioning (Linehan 1993). The focus of DBT lies in replacing maladaptive behaviors such as self-harm with adaptive skills, emphasizing a balance between change-focused techniques (e.g., cognitive modification) and acceptance-focused practices (e.g., mindfulness training).

To date, DBT is the most frequently studied treatment for BPD, with at least 13 RCTs of the full DBT program having been conducted in BPD-diagnosed samples. In general, when compared to TAU, DBT has been shown to significantly reduce behavioral symptoms often present in BPD, including non-suicidal self-injury and both suicide attempts and hospitalizations. However, several studies have found no difference between DBT and TAU in behavioral symptom decrease, suggesting that the efficacy of DBT for this symptom cluster has yet to be determined. Comparison trials of DBT against other active treatments for BPD, such as TFP or GPM, have found DBT to be comparable to these treatments in terms of behavioral outcomes and secondary symptoms such as depression and anxiety, although DBT did not improve primary BPD symptoms of anger and impulsivity (Clarkin et al. 2007). There is some evidence to suggest that DBT may reduce dropout rates among patients with BPD, with at least three studies specifically finding lower rates of dropout compared to TAU or community treatment by experts.

Unfortunately, given the focus on change in behavioral symptoms as outcome in DBT treatment studies, less is known regarding DBT's effectiveness in other BPD-relevant symptom domains, such as identity disturbance, emptiness, and relationship chaos. Some RCT evidence suggests that DBT may provide little benefit in terms of the identity-relevant construct of reflective functioning (i.e., one's capacity to reflect on the mental states of self and other) compared to TFP, a treatment that directly targets identity disturbance, another core feature of BPD. A variety of quasi-experimental and uncontrolled studies have shown varying levels of support for DBT, but these tend to focus solely on TAU as comparison (if one is present), and the implications of these findings are therefore limited.

Mentalization-Based Treatment. Bateman and Fonagy (2006) developed mentalization-based treatment (MBT) based on the developmental theory of mentalizing, which integrates philosophy (theory of mind), ego psychology, Kleinian theory, and attachment theory. Fonagy and Bateman posit that the mechanism of change in all effective treatments for BPD involves the

capacity for mentalization – the capacity to think about mental states in oneself and in others in terms of wishes, desires, and intentions. Mentalizing involves both (1) implicit or *unconscious* mental processes that are activated along with the attachment system in affectively charged interpersonal situations and (2) coherent integrated representations of mental states of self and others.

Bateman and Fonagy have conducted two large-scale RCTs of MBT supporting its use for BPD. In the first (Bateman and Fonagy 1999), the effectiveness of 18 months of an MBT day hospital program was compared with routine general psychiatric care for patients with BPD. Patients randomly assigned to MBT showed statistically significant improvement in depressive symptoms and better social and interpersonal functioning, as well as significant decreases in suicidal and parasuicidal behavior and number of inpatient days. Follow-up assessment also impressively showed maintained gains and increased remittance in the MBT condition compared to TAU up to 5 years after discharge.

The second RCT (Bateman and Fonagy 2009) compared 18 months of outpatient MBT with structured clinical management (CM), which focused on problem-solving skills and providing support. The number of suicidal and parasuicidal events and hospitalizations decreased at a significantly greater rate by posttreatment follow-up among the MBT participants compared with those in the CM condition. MBT participants also had greater declines in secondary symptom severity over 18 months of treatment, including depression, interpersonal function, social adjustment, and GAF ratings. Furthermore, the use of medication dropped significantly more in the MBT group than in the CM group. Collectively, these findings provide support for MBT as an efficacious treatment for BPD and indicate potential long-term benefit produced by this treatment, although follow-up analyses of outpatient MBT in particular are needed to ascertain maintenance of treatment effects.

Transference-Focused Psychotherapy. Another form of therapy showing evidence of efficacy for BPD is TFP, originating in the theoretical writings of Kernberg in the 1960s and 1970s and manualized in 2006 by Clarkin, Yeomans, and Kernberg. Although the stated goals of TFP are similar to those of DBT (i.e., to reduce self-injury and suicidality, to improve behavioral and emotional regulation, and to increase well-being), the focus of TFP is on the development of integrated representations of self and others, the modification of primitive defensive operations, and the resolution of identity diffusion that perpetuates the fragmentation of the patient's internal representational world (Yeomans et al. 2013). The analysis of the transference is the primary vehicle for the transformation of undifferentiated and unintegrated (e.g., split, polarized) to advanced (e.g., complex, differentiated, and integrated) and benign mental representations of self and others. In this treatment, a triad of *clarifications*, *confrontations*, and *interpretations* are used to both help the therapist understand the internal world of the patient and then to help the patient understand and come to terms with the conflicts involved in this world.

There is now accumulating evidence for the effectiveness and efficacy of TFP. At least three RCTs have examined the efficacy of TFP for BPD. One of these studies (Doering et al. 2010) found that 1 year of TFP outperformed TAU in terms of hospitalizations, suicide rates, BPD symptoms, psychosocial functioning, personality organization, secondary symptoms (e.g., anxiety and depression), and dropout rate, although neither condition produced reductions in self-harm. Another RCT (Clarkin et al. 2007) comparing TFP with two other active conditions (DBT and supportive psychotherapy [SPT]) found that TFP and DBT decreased suicidality over and above SPT and TFP and SPT showed improvements in anger and impulsivity over and above DBT. The TFP condition also showed unique improvements in reflective functioning (as mentioned above), attachment security, and a variety of aspects of aggression. The study further found roughly equivalent changes among the conditions in secondary features of depression, anxiety, and global level of functioning. In sum, TFP appears at least as efficacious as DBT, another major treatment for BPD, but TFP may also provide unique and

theoretically consistent improvements in areas such as attachment, identity, mentalizing, and aggression.

TFP was also examined as a control condition in a study of SFT (Giesen-Bloo et al. 2006). Both treatments were quite effective at reducing the range of BPD symptoms and improving quality of life, yet the authors found that several BPD symptoms (e.g., impulsivity, fears of abandonment, relationship chaos) improved more in SFT over TFP. However, some concerns regarding the adequacy of the TFP implementation in this study (Yeomans 2007) indicate that results may be unfairly partial toward SFT, casting some doubt on the generalizability of the study in terms of TFP's efficacy for BPD.

As with DBT, there have also been some quasi-experimental or uncontrolled studies of TFP which have shown good results, but again these results must be interpreted with care. It is also worth noting that TFP, consisting of two 1-h sessions per week, requires fewer weekly hours patient contact compared to DBT (3–4 h) and MBT (2.5 h), indicating its efficiency in the treatment of BPD.

Schema-Focused Therapy. A fourth treatment modality that has demonstrated efficacy in the treatment of BPD is Young's SFT, developed in the early 1990s. SFT draws from the domains of CBT, gestalt therapy, and psychodynamic theory in an attempt to alter maladaptive schemas formed early in development that generate and maintain dysfunctional views of oneself and others. Giesen-Bloo et al. (2006) provide initial support for SFT, as described above in the discussion on TFP, although these results must be considered preliminary, given the concerns we have noted previously. However, more recent data provide continued evidence for SFT provided in a group format as an efficacious treatment for BPD. Farrell et al. (2009) report data from a small sample of women with BPD ($N = 32$), comparing 8 months of group-based SFT with TAU. At the end of treatment, 94% of the women in the SFT group no longer met diagnostic criteria for BPD, a significantly greater reduction compared to the 16% who no longer met criteria in the TAU group. Furthermore, SFT led to significantly greater improvements on levels of general functioning and psychopathology in comparison to TAU. This study, therefore, provides evidence for the efficacy of SFT for BPD, although further research with larger samples and increased methodological rigor is needed to confirm this treatment's utility.

Standard Cognitive Behavioral Therapy. Standard cognitive behavioral therapy has also been utilized with BPD samples, although there is a dearth of literature supporting this treatment. Two trials have found limited relative benefit of CBT for BPD, with theoretically consistent improvements in CBT over TAU for suicidality, maladaptive schemas, and anxiety and distress, but not other behavioral and personality problems (Davidson et al. 2006), and no benefit of cognitive therapy over supportive therapy. There has also been one RCT of manual-assisted cognitive treatment (MACT), a highly structured adaptation of CBT, which has shown benefit for self-harm but has not been evaluated for other BPD symptoms (Weinberg et al. 2006). In sum, standard CBT may lack the focus on interpersonal dynamics, integration of different aspects of the self, and/or emphasis on acceptance reflected in the treatments described above to be a truly efficacious treatment modality for BPD.

Dynamic Deconstructive Psychotherapy. DDP is a 1-year psychodynamic treatment package that addresses three neurocognitive functions distorted in individuals with BPD: *attribution* (thoughts of value or motive assigned to people and behaviors), *association* (linking symbols or language to experiences or physical characteristics), and *alterity* (ability to realistically and objectively view the world and others). One RCT has been conducted testing 1 year of DDP versus TAU (Gregory et al. 2008), showing evidence for the efficacy of DDP for 30 BPD patients with comorbid alcohol use disorder up to 18-month follow-up. However, the small number of treated patients (15 in each group), as well as the 33% dropout rate in the DDP group (compared to 20% in the TAU group), makes these results preliminary.

Cognitive Analytic Therapy. Cognitive analytic therapy (CAT) is an integrative therapy combining psychoanalytic theory with cognitive

therapy principles and focusing on triggers of vacillating "self-states" in BPD. CAT has shown to be effective and to provide some benefit over TAU but limited effect in adolescents with BPD features. Further research is needed to determine if CAT is a reliable effective treatment for BPD and comparable to other BPD treatments.

In sum, four treatments – DBT, TFP, MBT, and SFT – appear similarly efficacious for BPD (although with varying levels of theoretical and empirical support), with each potentially effecting change in slightly different treatment targets (e.g., TFP and reflective function).

Beyond the programs of treatment outlined above, several therapeutic models have arisen intended to be add-on treatments to standard care for BPD. Perhaps the most studied of these is Systems Training for Emotional Predictability and Problem Solving (STEPPS), a group-based program that combines CBT and family systems principles. Other augmentation treatments include emotion regulation group therapy (ERGT) and motive-oriented therapeutic relationship. Finally, as a serendipitous by-product of novel treatment trials for BPD, several forms of "generalist treatment" were developed as control conditions that themselves provided good outcome for patients with BPD, including "structured clinical management," "community treatment by experts," "good clinical care," and "good psychiatric management" (GPM), the last of which, given its increasing evidence base as a stand-alone treatment for BPD, we describe in more detail below.

Systems Training for Emotional Predictability and Problem Solving. In 1995, Blum and colleagues developed STEPPS, a manualized group treatment for BPD designed to augment standard care and utilize both cognitive behavioral skills training and emotion regulation techniques as well as a family systems component that incorporates family members and close friends into the treatment. STEPPS has generated a small body of literature indicating its effectiveness for those with BPD. At least two RCTs have shown the addition of STEPPS group to TAU to provide significant improvements over TAU alone for BPD symptoms, as well as secondary symptoms such as depression and level of functioning and well-being. Neither of these studies found meaningful benefits of STEPPS for behavioral problems such as self-injury. Furthermore, in one of these studies, the benefits of STEPPS concerningly disappeared by 1-year follow-up, although others found sustained advantages to STEPPS combination therapy. Despite these positive results, a significant drawback of these studies is the fact that the STEPPS condition necessarily involved an additional 2 h of face-to-face intervention with participants in the STEPPS augmentation conditions, such that this increased treatment dosage may have driven positive effects. However, as STEPPS becomes an increasingly viable option for BPD treatment, one potential advantage it provides is that it is designed to be conducted within 20 weeks, a shorter time frame than most current treatment packages for BPD.

Emotion Regulation Group Therapy. Emotion regulation group therapy (ERGT), a treatment package drawing largely on both acceptance and commitment therapy and DBT, focuses on increasing emotional awareness and emotion regulation capabilities (Gratz and Gunderson 2006). Preliminary evidence from two small RCTs of ERGT suggests ERGT+TAU is a promising treatment for individuals with BPD, providing improvements in emotion regulation, emotional acceptance, depression, anxiety, self-harm, and borderline symptomology over and above TAU alone. Furthermore, only 8% of patients dropped out of therapy, perhaps a result of the short-term nature of ERGT. Although these results appear quite positive, especially given the brevity of the ERGT treatment protocol making it a highly practical treatment program, the limitations of small samples and potential for treatment outcomes to be explained by increased treatment dosage alone temper the conclusions that can be drawn regarding ERGT for BPD.

Motive-Oriented Therapeutic Relationship. Motive-oriented therapeutic relationship (MOTR) has also been examined as an addition to TAU for individuals with BPD. Similar to both STEPPS and ERGT, MOTR is a short-term treatment augmentation for BPD, although it is unique in that it does not involve a group component but is instead

assimilated into individual therapy. MOTR is designed to be incorporated into the first 10 weeks of treatment, focusing on the interpersonal difficulties common in BPD by (1) identifying and clarifying the motivation underlying the patient's behaviors and (2) persuading the patient that his or her needs and wants will be fulfilled in an unproblematic way through the therapeutic relationship itself. Results of two RCTs of MOTR found improvements in interpersonal problems, therapeutic alliance, and dropout, but not BPD symptoms themselves (e.g., Kramer et al. 2011). These results suggest that MOTR is a short-term additive treatment option that may increase patients' interpersonal efficacy and willingness to stay in treatment but that other treatment tailored to BPD is necessary in combination with MOTR to effect change in BPD-specific symptoms.

Good Psychiatric Management. GPM focuses on the interpersonal problems and specifically interpersonal hypersensitivity, endemic to BPD (Gunderson and Links 2014). GPM incorporates aspects of a variety of therapy orientations, including interpretations of anger and acting out (PDT/TFP), psychoeducation and fostering social skills (CBT/DBT), and a focus on theory of mind and reflective functioning (MBT). What primarily sets GPM apart from the treatments reviewed above is that it does not claim to be a stand-alone or specialized treatment for BPD but, with roots in Winnicott's ideas of "good enough parenting," is instead designed as a *generalist* treatment, which can be implemented by all manner of practitioner, with more severe cases of BPD potentially being referred to *specialist* treatments such as TFP and DBT.

Empirical support for GPM comes primarily from the original RCT using GPM as a control condition against DBT. Contrary to initial study hypotheses, GPM was found to be as effective as DBT across all outcome measures, including self-harm, hospitalizations, BPD symptoms, a range of secondary clinical correlates such as depression, and functioning variables. These results suggest that GPM may be a viable alternative to specialized treatments for BPD, especially in contexts in which such treatments are not available.

In sum, the research base for treatment for BPD is established and growing, with far more clinical research on BPD than any other PD. Yet, current treatments for BPD still only show moderate efficacy and high rates of dropout, clearly indicating there is much more work to be done regarding improving BPD treatments. Furthermore, although the effectiveness of some programs of therapy has yet to be clearly indicated via empirical research, there is no BPD treatment that appears clearly more impactful than the rest. Identifying what works for whom may be an especially important avenue for future BPD treatment research, in order to increase both efficacy and retention.

Narcissistic Personality Disorder. To date, there have been no clinical trials of psychotherapy specific to the treatment of narcissistic personality disorder (NPD). Given the limited evidence base, existing treatment recommendations are primarily based on theory and clinical experience. Among others, Levy (2012) has recommended that, given the conceptual similarities and comorbidities, patients with NPD should be treated in empirically supported psychotherapies for near-neighbor disorders such as BPD, particularly in those empirically supported treatments that have been modified appropriately. A number of clinical researchers have suggested specific modifications to such treatments when working with patients with NPD based on the unique dynamics and challenges posed by therapy with patients with this disorder (e.g., Levy 2012). In particular, because fragile self-esteem is a common feature in NPD – including in patients who present with a grandiose self-image – a particular focus on delivering interventions tactfully is recommended when working with this population (Levy 2012).

One point of agreement among researchers and clinical writers is that treating patients with NPD poses a number of challenges. Traits associated with NPD such as grandiosity have been found to predict poorer outcome and increased risk of dropout (Levy 2012). Similarly, results from follow-up studies of psychotherapy suggest that patients with NPD generally experience poorer long-term outcomes, and clinical experience holds that patients with NPD may find it difficult

to tolerate being in treatment because they may experience allowing the therapist to help them as a threat to self-esteem (Levy 2012).

Antisocial Personality Disorder. As with many personality disorders, individuals with antisocial personality disorder (ASPD) are unlikely to seek treatment explicitly for these characteristics and behaviors but rather for substance misuse, anger, depression, or at the suggestion of family. In fact, treatment may be court ordered or may occur within the context of the legal system.

Given a tendency toward irresponsibility and impulsivity, treatment compliance is a concern when treating individuals with ASPD, as is monitoring engagement in illegal behaviors during treatment. Acting out is common among these individuals, and outpatient care is prioritized over inpatient hospitalization as individuals with ASPD are likely to be disruptive to the therapeutic milieu in residential treatment or inpatient settings. Given these concerns, treatments with firm structure and behavioral controls are likely to be the most effective for individuals with this constellation of symptoms.

Preliminary research shows evidence for the value of psychodynamic treatments for ASPD. In one RCT, Bateman and Fonagy (2008) found the potential for reducing violent episodes in individuals with comorbid BPD and ASPD using both individual and group MBT. Compared to a control group receiving structured clinical management, a manualized control therapy focusing on problem-solving and support, MBT was more effective through a focus on improving mental flexibility and mentalizing capacity. Although these findings need replication in a sample without comorbid BPD, the results from this RCT are promising.

There have also been attempts to modify DBT for use with criminal offenders and forensic populations, with some positive but mixed results in terms of decreased problematic behaviors; however, given the small sample sizes and high dropout rates in these studies, it is difficult to draw meaningful conclusions from this research at the present time.

Encouragingly, research suggests that if antisocial patients are able to form a therapeutic alliance with their clinician, they are more likely to show improvement in psychotherapy. Gerstley et al. (1989) found that for men with ASPD and opioid addiction receiving either drug counseling only, supportive/expressive psychotherapy plus drug counseling, or cognitive behavioral therapy plus drug counseling, therapeutic alliance correlated with decreased substance use and employment status 7 months after treatment across the psychotherapy groups, but not the counseling only condition. Although Gerstley and colleagues note that not all individuals with ASPD are able to form an effective therapeutic alliance, targeting the patient-therapist alliance may be an important part of treatment for these individuals.

Cluster C PDs

Although highly prevalent in both the general population and clinical settings, there are relatively few psychotherapy efficacy studies specific to Cluster C personality disorders. Svartberg et al. (2004) report findings from an RCT in which they compared a short-term psychodynamic treatment with CBT for Cluster C PDs and found significant reduction in symptomatology for the psychodynamic group but not the CBT group (although there were no statistical differences between the two groups). Similarly, in a study comparing a brief adaptive psychotherapy, short-term dynamic psychotherapy, and a waitlist control, Winston et al. (1994) found that individuals with Cluster C PDs or Cluster C PD features significantly improved with short-term psychodynamic treatment where confrontation, impulses, and defenses were explicitly addressed.

Hardy et al. (1995) report the outcome for a subsample of patients with Cluster C PDs who had participated in a larger study comparing interpersonal-psychodynamic psychotherapy with cognitive therapy (CT) for major depression. Findings indicated that Cluster C patients continued to show more severe symptomatology than non-Cluster C patients if they received dynamic therapy, but not if they received CT.

Hellerstein et al. (1998) report evidence for brief supportive psychotherapy and short-term dynamic psychotherapy in the treatment of a sample of a large proportion of Cluster C PD-diagnosed outpatients (41%). After an

average of 30 weeks of treatment, both treatments showed improvements in patient-identified primary concerns, general symptomatology, and interpersonal functioning. Similarly, Muran et al. (2005) found short-term psychodynamic, cognitive behavioral, and brief relational therapies produced equivalent improvements in general symptoms, specific target complaints, and interpersonal functioning in a sample of 84 outpatients with a Cluster C PD or PDNOS diagnosis.

Obsessive-Compulsive Personality Disorder. Characterized by a pattern of rigidity and perfectionism, much of the literature on the treatment of obsessive-compulsive personality disorder (OCPD) discusses the impact of comorbid OCPD traits or diagnosis in individuals with obsessive-compulsive disorder (OCD). This research provides mixed results that OCPD is associated with worse outcomes in some studies and improvement in others.

Looking at the treatment of OCPD itself, the literature suggests that compared to other Cluster C personality disorders, individuals with OCPD tend to show greater improvement in treatment. Winston et al. (1994) found that short-term psychodynamic interventions were especially effective for individuals with OCPD features. Furthermore, with regard to specific targeted interventions, in a 52-week trial of cognitive therapy for individuals with avoidant or obsessive-compulsive personality disorders, Strauss et al. (2006) found that stronger early alliance and the corrective experience of repairing alliance ruptures predicted significant improvement in personality pathology common to individuals with OCPD. An uncontrolled trial of group-based CBT has also shown some benefit for OCPD patients, although benefits were limited to patients with greater pretreatment distress.

Avoidant Personality Disorder. There are a number of controlled studies for avoidant PD specifically. Overall, these studies suggest that improvements can be found with treatments that employ social skills training alone or in combination with exposure and cognitive techniques and that CBT may outperform dynamic treatments for AVPD; however, many patients did not show clinically significant improvement or generalization to other contexts, and additional research is needed with regard to this issue.

Personality Disorder Not Otherwise Specified

Other specified or unspecified PDs (commonly referred to as personality disorder not otherwise specified or PDNOS) are diagnostic categories used to subsume all displays of PD-level clinical disturbance that do not meet the criteria for any one of the other specific PDs. The latest version of the *DSM* splits PDNOS into two subcategories based on the amount of specificity regarding symptoms provided by an assessor, but the concept remains the same. There have been no treatment studies designed specifically for PDNOS to date. However, reports of RCTs for PDs that have included high rates of PDNOS have shown that psychodynamic treatments may be especially helpful for PDNOS and may outperform CBT in terms of retention rates, although with equivalent improvements in symptom domains. Furthermore, a range of integrative short- and long-term outpatient, day hospital, and inpatient treatments may each be effective for PDNOS patients. A recent review (Johnson and Levy 2017) suggests that individuals with PDNOS may present as less severe than other PDs, in part due to the lack of comorbid PDs required by the PDNOS diagnosis, which may have implications for treatment. Similarly, research has suggested that BPD and AVPD symptoms may appear commonly in PDNOS cases, perhaps in part due to the high prevalence rates of both of these disorders, suggesting that treatment principles utilized for these specific PDs may also be helpful for many individuals with a PDNOS diagnosis (Johnson and Levy 2017).

Common Challenges for Therapists Treating PDs

Given the chronic nature of PDs and the tendency for PD symptoms to be severe and pervasive – impacting the way patients perceive, think about, and relate to themselves and others – these disorders can be especially challenging for clinicians to treat. The symptoms and behaviors common to

personality disorder may make it more difficult for patient and therapist to collaborate effectively in treatment. As discussed below, therapists may have strong, intense, and uncomfortable reactions to patients with PDs, sometimes referred to as countertransference. Feelings evoked in therapists may lead them to enactments of problematic behaviors or roles or to engage in iatrogenic behaviors (Levy and Johnson 2016). Some PDs may be associated with unique challenges; for example, with patients with ASPD, there may be a higher risk for criminal acting out or manipulation of the therapist. Patients with BPD may engage in suicidality or self-injury and experience frequent, sometimes "unrelenting" crises (Linehan 1993). Additionally, in settings with multiple care providers, patients with BPD may tend to split providers into idealized and devalued groups, which, if not well-managed, can impact the treatment team's ability to collaborate effectively. The potential for such risks, the possibility for intense emotional reactions on the part of both patient and therapist, the importance of maintaining the treatment frame, and the length of treatment required combine to make the treatment of PDs challenging.

The Therapeutic Relationship

The interpersonal dysfunction associated with PDs can have a significant impact on the therapeutic relationship, through the avenues of the transference and countertransference. Transference refers to the patient's enduring patterns of cognition, emotion, and behavior originating in prior relationships that are manifested in and rigidly applied to the relationship with the therapist. Patients with PDs may be especially likely to experience strong transference reactions. For example, the splitting (rapid shifts in views of self and other, often between idealization and denigration) and fear of abandonment characteristic of BPD may be displayed in the transference and may interfere with the therapist-patient relationship. As such, rapid shifts in transference reactions are common among patients with BPD and can be an important focus of treatment (Clarkin et al. 2006).

Countertransference represents the reactions that therapists have toward their patients, which can be influenced by both therapists' own histories and patient characteristics. As such, similar to transference, while therapists may experience a range of reactions over the course of treatment with any given patient, some patterns of typical reactions with patients with PDs have been observed based on the characteristics of PD symptoms. For example, when working with patients with NPD, therapists may feel incompetent, bored, dismissed, belittled, or, by contrast, overly idealized. Although these reactions on the part of the therapist may negatively affect the treatment if not appropriately metabolized, they may also serve as useful indicators of the patient's internal world and signals to the therapist to utilize specific interventions (Clarkin et al. 2006).

Perhaps the most common way of assessing the interpersonal context between patient and therapist is via the working therapeutic alliance. The therapeutic alliance consists of mutual liking and respect, as well as agreement on the goals and tasks of therapy, and has been found to be consistently associated with positive outcome in psychotherapy. However, the association between strong alliance and outcome may be weaker in patients with PDs for multiple reasons, including the interpersonal dysfunction of PDs may interfere with establishing an alliance or may actually contribute to a superficial but illusory or distorted alliance (i.e., "pseudo"-alliance) and improvement in interpersonal functioning and healthy relationship formation is likely to be a *target* of treatment with PDs, rather than purely a mechanism of change. One study of alliance in psychotherapy for PDs, for instance, found that patients with Cluster A PDs had difficulty establishing a working alliance at all, while therapists rated the alliance with Cluster B patients negatively. Furthermore, patients with Cluster B PD traits (e.g., impulsivity, dysregulation, and affective lability) have been found to experience more ruptures in the therapeutic alliance even after it has been established, while Cluster C patients may not display *more* ruptures than non-PD patients but may take significantly longer to experience a repair of these ruptures, specifically in less

interpersonally based treatments. Given the different interpersonal complications associated with each cluster of PDs, some have suggested unique modifications to maintain an alliance with different presenting concerns. For instance, when working with Cluster B patients, therapists may do well to be mindful of crossing interpersonal boundaries to avoid colluding with the poor boundary setting common among these patients (Levy in Magnavita et al. 2010). Directly addressing ruptures in the alliance when they occur has also been shown to improve outcome in psychotherapy for Cluster B and C patients.

Burnout

Therapists of patients with PDs may be at risk for experiencing burnout as a result of the challenges associated with treating personality pathology. Burnout results from prolonged stress related to work, causing physical, cognitive, and emotional dysfunction in professionals who were previously motivated and high-functioning. In the context of psychotherapy for PDs, providing treatment can result in emotional exhaustion, a reduced sense of personal efficacy, and a tendency to feel distant or disconnected or view patients in a cynical manner. This risk may be especially elevated when working with patients who engage in self-injury or when therapists have unrealistically high initial expectations about the likelihood and rate of improvement. For instance, therapists treating patients with BPD have been found to display high levels of burnout and may be at risk for engaging in iatrogenic behaviors, such as reinforcing self-destructive behaviors rather than working to eliminate them or granting a patient's request for frequent between-session phone contact in response to accusations about the therapist's sensitivity, rather than exploring the meaning of such requests and accusations (Clarkin et al. 2006). Factors that may mitigate these risks include appropriate training in the treatment of PDs and ongoing supervision or consultation (Linehan 1993; Levy in Magnavita et al. 2010).

General Treatment Implications When Working with PDs

To make more practical this review of the PD treatment literature, we attempt to summarize the treatment implications for personality pathology generally. Given that the majority of research has been conducted on a few disorders, primarily BPD, the following implications are admittedly weighted toward BPD pathology and may only loosely be applicable to other clusters of PD. The following implications focus on the *framework* of recommended treatments, the *dosage* or amount of treatment needed to produce meaningful change, and the *therapist* qualities or level of training necessary for successful therapy implementation.

PD Treatment Framework

PD treatments place a good deal of emphasis on maintaining a structured (but not rigid) treatment, beginning by dedicating early sessions to discussing the treatment frame or treatment contract with patients and providing diagnostic feedback (Levy in Magnavita et al. 2010). The treatment frame generally consists of the therapist and patient collaboratively setting treatment goals that are as specific and attainable as possible, encompassing issues of work, responsibility, interpersonal relations, and leisure. Therapists may also educate patients regarding the expected outcomes and time course of their involvement in therapy. The treatment frame articulates the patient and therapist's roles and responsibilities in the treatment. The patient's responsibilities typically include attending sessions regularly, working toward the treatment goals, engaging in assigned homework or practice of new skills outside of session, reducing self-destructive behaviors, making an effort to report thoughts and feelings freely without censoring, and making an effort to reflect on those thoughts and feelings, as well as on the therapist's comments (Linehan 1993; Yeomans et al. 2013).

Setting the frame also involves providing at least some level of detail regarding the underlying treatment rationale to patients. Although theories of personality and its difficulties are not new,

existing as far back as the Greek physician Hippocrates' descriptions of various temperaments deriving from four bodily fluids (circa 400 BC), comprehensive and complex theories of personality underlie modern treatments for PDs. The psychoanalytic writings of Kernberg, for instance, place a fractured identity and disturbed mental representations of self and other at the crux of many PDs, a theory that has undergirded treatments for PDs of a range of severity. Relatedly, Fonagy and colleagues have posited impaired development of the capacity to reflect on one's own and others' thoughts, feelings, and other mental states (i.e., mentalization) to underlie personality pathology. From a behavioral perspective, Linehan has elucidated the interactions among biology and environment in contributing to the development of personality-related difficulties. Others have approached providing a treatment rationale from the perspective of distilled principles relevant for improving functioning, such as educating BPD patients on interpersonal hypersensitivity as is done in GPM (Gunderson and Links 2014). The model from which the therapist is working is conveyed in some portion to patients and is adapted or contextualized to the specific presentation of each patient in order to elicit investment in the therapy and its tasks, facilitate a shared language between therapist and patient, and convey to the patient the therapist's understanding of his or her difficulties and foster trust in the therapy process (Linehan 1993; Yeomans et al. 2013). The incorporation of a clear treatment frame and treatment rationale can also help provide a safe and stable space for the patient to explore painful interpersonal dynamics and can help minimize the risk of therapist enactments or burnout. An explanatory framework may itself be an important agent of positive change for patients and may instill hope, which is a crucial ingredient in psychotherapy's efficacy.

As part of (or prior to) setting the frame of treatment, it is recommended to provide the patient with diagnostic feedback (Clarkin et al. 2006). Having a mutual understanding of the patient's difficulties and a shared language with which to proceed with treatment is essential when working with PD patients (Levy 2012). However, PDs are often missed in the absence of structured interviews or inappropriately diagnosed as a non-PD disorder such as major depression, anxiety, or bipolar disorder. In fact, it may take years for an individual with a PD to receive an accurate diagnosis, delaying effective treatment and prolonging distress. Even when a PD diagnosis is suspected or confirmed, many practitioners are hesitant to share the diagnosis with their patient due to unfamiliarity with PDs, misconceptions that PDs are untreatable, and a fear of the stigma associated with a PD diagnosis and the often-inaccurate assumption that the patient will react negatively to receiving it. Instead, research and clinical wisdom are clear that providing diagnostic feedback with PD patients is crucial for guiding treatment, fostering the therapeutic alliance, and encouraging patient autonomy (Clarkin et al. 2006; Levy 2012), and in fact that sharing the diagnosis can be reassuring to patients (Yeomans et al. 2013) and that patients prefer to be given a PD diagnosis and discuss the stigma associated with it, rather than have it kept from them.

Paralleling the importance of the flexible structure of most PD treatments, many of the theories that give rise to these treatments themselves were flexibly and integratively developed out of treatments originating in a singular school of thought or treatments that called for too much or too little regiment for PD patients. For instance, Kernberg highlighted the centrality of affect in the explication of mental representations of PD patients and the importance of addressing the "here-and-now" relationship between patient and therapist, in contrast to the psychoanalytic focus on historical relationships of the time. Linehan developed DBT out of standard CBT by incorporating acceptance strategies to offset the change-based focus of CBT, which often proved ineffective with women with severe suicidality, self-injury, and emotion dysregulation. Furthermore, the majority of hospital-based programs for PDs tend to incorporate a range of therapeutic modalities and provide multifaceted and highly integrative treatment packages to patients presenting with severe personality pathology. Such integration appears crucial to address the complexity of PD presentations (Levy in Magnavita et al. 2010). In fact,

evidence consistently shows that complex and severe PDs may be relatively untreatable through unmodified CBT or PDT, suggesting integration is vital for improving the lives of patients with these disorders.

PD Treatment Dosage

Research has consistently found that patients with PDs require more contact hours than patients with many other disorders before showing improvement. The treatment dosage required for improvement has been found to range between 50 and 200 sessions depending upon the study (Perry et al. 1999); approximately 100 sessions may be an optimal treatment dosage for psychodynamic psychotherapy. Increased treatment dosage has also been shown to improve outcome in partial hospitalization and inpatient treatments for PDs (Bartak et al. 2011).

Maximizing treatment dosage generally occurs via a combination of long-term therapy and patient participation in multiple therapy sessions or session formats per week (Levy in Magnavita et al. 2010). Clinical trials for BPD, for instance, generally last at least 1 year (compared with approximately 16 weeks for many non-PD disorders), and manuals suggest that a longer treatment duration may be necessary for full recovery (Bateman and Fonagy 2006; Clarkin et al. 2006; Linehan 1993). Even treatments referred to as "short-term" that have shown efficacy for Cluster C PDs tend to take many months (often eight or more, e.g., Svartberg et al. 2004), more than what is typical for structured treatments for non-PDs. In fact, given the chronic nature of PDs, there is evidence to suggest that up to 25% of PD patients may show diagnostic remission after each year of therapy, which outstrips the natural remission of severe PDs by seven times (Perry et al. 1999). Evidence suggests that a long-term course of therapy may be especially helpful not only for symptom reduction but also for general psychosocial functioning (Leichsenring and Leibing 2003), which may be the most persistent and difficult-to-address feature of PDs, as many patients may see symptom remission in shorter periods of time. Given the tendency for acute PD symptoms to improve more quickly than general functioning, some have suggested phase-based care, in which first fostering hope, then managing symptoms, and finally improving functioning is addressed in sequence (Levy 2008; Paris 2013), a suggestion that has received some empirical support and has been incorporated into PD treatment manuals (e.g., Clarkin et al. 2006; Linehan 1993).

As a second means to maximize treatment dosage, many treatments also recommend frequent outpatient sessions in the form of twice-weekly individual sessions or weekly group skills training in addition to individual sessions, especially for high-risk disorders such as BPD (e.g., DBT, TFP, MBT, SFT). Often this may amount to up to 4 h of therapy per week, even in outpatient settings. Evidence supports this standard among PD treatments, suggesting high density of treatment is important both for the reduction of symptoms and maladaptive behaviors as well as improvements in interpersonal functioning. Augmentation with group therapy may also confer unique benefits given the interpersonal disruption characteristics of patients with PDs, providing a useful "training ground" for healthy interpersonal interactions, facilitating skills learning, normalizing shared experiences of early stressors, and generating interpersonal material of use for therapists to explore. Several of the treatments outlined previously (e.g., DBT, MBT, group CBT for OCPD) incorporate group components, and several add-on group treatments have been developed for BPD in particular (e.g., STEPPS, ERGT). Furthermore, other treatments may be effectively combined with concurrent group therapy (e.g., TFP; Clarkin et al. 2006).

Unfortunately, although the extant evidence suggests patients with PDs may require a higher dose of treatment than other patients, they may be less likely to obtain it. Research has noted that patients with PDs are significantly more likely to drop out of treatment than patients with other disorders, with a mean dropout rate of 32% for patients with BPD, for instance, compared with a rate of 20% across a range of other non-PD disorders. Difficulties in the therapeutic relationship may make premature dropout more likely. Given this high rate of dropout, many treatments for PDs include a focus on making sure patients

clearly understand the demands of treatment and preparing them for likely difficulties (e.g., intense negative emotional reactions to the therapist) in hopes of minimizing the risk of dropout when such difficulties occur.

Characteristics of Effective PD Therapists

Given the challenging clinical presentation and countertransferential reactions endemic to working with PD patients, certain therapist characteristics may be especially important. In general, there are individual differences in therapist effectiveness, such that some therapists have better outcomes on average than others; these differences may be greater in treatment for patients with more severe disturbances, such as those with PDs. Important characteristics shared by effective PD therapists include comfort with long-term treatments involving intense emotional relationships, the capacity to be patient and to tolerate one's own negative emotions as well as those of the patient, and a willingness to approach treatment in a creative, flexible, and open-minded manner. Effective treatment also requires the therapist to avoid rigidity while ensuring that the boundaries of treatment are observed. The personal characteristics that facilitate therapist effectiveness in general – such as interest in others, warmth, empathy, integrity, self-insight, and the capacity to commit to working with the patient – are also likely to be especially critical in the treatment of PDs.

Therapists working with PDs must play an active role in the therapy, both in individual sessions and in leading interpersonal or skills-focused groups. In fact, this is one important distinction between dynamic treatments for PDs and traditional psychodynamic/psychoanalytic treatments, in which the therapist is often passive or withdrawn. However, an active therapist needs not be a *directive* therapist, as is the case in TFP, which is in contrast to the transparent and directive therapist employing a cognitive behavioral treatment. Regardless of their level of directiveness, active PD therapists tend to follow a hierarchy of treatment targets or set of focused principles during therapy sessions while maintaining a mindful, balanced, mentalizing stance aligned with or modeling healthy behaviors and ways of thinking on the part of the patient (Bateman and Fonagy 2006; Clarkin et al. 2006; Linehan 1993). In-session hierarchies generally orient the therapist first to notice and address self-destructive or therapy-interfering behaviors and then to address intense emotions as well as improve emotion regulation and adaptive behaviors and functioning (Clarkin et al. 2006; Linehan 1993). A PD therapist may also be actively tracking the patient's in-the-moment affect or noting cognitive distortions and drawing attention to conflicting information that arises from the patient. An active therapist – directive or not – may be especially important when treating the more erratic and dysregulated Cluster B PDs, rather than other PDs, given evidence for less active supportive psychotherapy for OCPD (Hellerstein et al. 1998).

Given the challenges inherent in treating PDs, specialized training of therapists is important both to teach therapist's therapeutic approaches tailored to the treatment of PDs and to help them to manage their reactions to patients with PDs. First, many of the aforementioned PD treatment programs require intensive training before therapists may apply them fully. The evidence suggests that unmodified standard therapy regimens (e.g., standard CBT) may be ineffective for many individuals with severe PD such as BPD, mandating the need for therapists providing treatment to these PD patients to receive specific training in empirically supported modified integrative PD treatments. However, generalist treatment models are gaining traction (e.g., GPM), with the express goal of allowing more practitioners some, if not complete, competence in addressing personality pathology. Unfortunately, access to training in PD treatments is often limited (Levy in Magnavita et al. 2010).

Second, in the absence of formal training in a PD treatment modality (a less than ideal scenario), it is vital that clinicians at least develop expertise in *identifying* and diagnosing these disorders, given the prevalence of PDs and the importance of accurate diagnostic conceptualizations (Levy in Magnavita et al. 2010). This is important even for clinicians treating a non-PD disorder, as PDs may

negatively affect the course of these treatments. Furthermore, training aimed at reducing stigma and developing a better understanding of patients with PDs may help improve the quality of care. One common misconception about PDs is that they are not treatable, which can impact the quality of care offered to patients diagnosed with a PD. Negative beliefs about the reasons why patients with PDs may engage in "challenging" behaviors such as self-injury or suicidality may make it more difficult for clinicians to remain empathic and to respond to these behaviors in a therapeutic manner. Stigma around BPD in particular may increase the intensity of clinicians' responses to patients with the disorder, which may be mitigated by appropriate training and education about the disorder. Accumulating evidence suggests the utility of brief workshops for increasing provider empathy and willingness to work with individuals with a PD and decreasing negative attitudes toward these patients. Finally, appropriate training can also help clinicians manage the therapeutic relationship in a way that promotes the building of a therapeutic alliance and the management of any reactions therapists may have when working with patients with PDs.

Finally, many PD treatments explicitly address the challenges faced by working with personality pathology and the burnout that can occur among treatment providers by delineating a means of therapist consultation as part of the treatment program (Levy in Magnavita et al. 2010). For instance, some form of regular therapist consultation/peer supervision meeting is outlined in TFP, DBT, and GPM, all treatments for BPD, a disorder associated with high levels of therapist burnout, enactments, and other difficult interpersonal dynamics between the therapist and patient (Clarkin et al. 2006; Linehan 1993; Gunderson and Links 2014). Although there is no empirical evidence to date on the importance of such consultation on burnout or therapy process or outcome, clinical wisdom highlights the need for this professional support system.

Future Directions in PD Treatment Research

The state of the psychotherapy literature for PDs is mixed. On the one hand, it is clear that a range of treatments from both cognitive behavioral and psychodynamic orientations show efficacy in randomized control trials and evidence when considering findings across meta-analyses. Although the effect sizes are often small to moderate, the clinical significance is meaningful in that many individuals treated with these psychotherapies will be helped compared with those not receiving treatment or in nonspecialized treatment-as-usual. Nonetheless, these effects can likely be improved, in order to help even more individuals, by filling significant gaps in the extent literature. Certain disorders such as BPD have received some consideration, but other serious disorders such as narcissistic and antisocial personality disorder, and other common and debilitating disorders such as avoidant, dependent, and schizotypal PD, for example, have received very little attention. Given the high prevalence of PDs and the drastic toll they take on public health, healthcare services, caregiver well-being, and the individuals who bear them, several important next steps are necessary for PD treatment research, of which we highlight four:

1. **Further exploration of effective PD treatment principles**. Despite the complexity and comprehensive nature of most PD treatments, little remains known regarding what facets of these treatments are most important or confer the most benefit for patients. Many have written on the importance of identifying the most effective principles of these treatments, as well as those that cut across treatments, in order to maximize efficacy, given that often only half of patients respond positively to current treatments. For instance, one existing common PD treatment principle is addressing maladaptive or inaccurate mental representations of the patient's self and important others (including the therapist). Many treatments, such as CBT/SFT (schemas), TFP (object-relation dyads), and CAT (self-states), place the

delineation and modification of these mental representations at the forefront of treatment. Further research is needed on the specific active ingredients of efficacious treatments for PDs and ideographic patient referral based on individual differences specific to different PD theories (e.g., impulsive patients in DBT vs. identity disturbed patients in TFP) (Levy 2008). This latter point speaks to the importance of maintaining and increasing access to multiple treatment options for each PD, as different patients among these heterogeneous diagnoses may respond better to different treatments (Levy in Magnavita et al. 2010).

2. **Follow-up assessment**. Although naturalistic follow-up studies of PD patients suggest that the symptoms (but not functioning) associated with personality pathology may remit naturally over time, some evidence suggests that such gains are minor compared to gains effected by PD-focused treatments (e.g., Perry et al. 1999). However, the literature regarding long-term maintenance of PD treatment gains is sparse as many PD treatments involve only short-term follow-up assessments, if at all (Levy 2008). Given the entrenched and chronic nature of personality disorders, long-term follow-up is central for establishing the significance of these treatments, as some preliminary evidence indicates PD treatments, especially those incorporating multiple phases of care, may be able to produce lasting effects. Furthermore, follow-up evaluations should monitor both statistically *and clinically* significant change in PD symptoms and level of functioning, given the importance of both in determinations of a treatment's effectiveness (Levy 2008).
3. **Cost-effectiveness research**. Further research is needed to determine the treatment dosage and complexity of services that optimizes cost-effectiveness for the various PDs. Cost-effectiveness can be considered both in terms of the cost involved in providing psychotherapeutic services but also, given the high rates of expensive healthcare utilization among many with PDs, in terms of reductions of symptoms or behaviors (e.g., suicide attempts) that may contribute to ER visits and other costly emergency services. A recent systematic review found specialized empirically supported treatments for BPD to be cost-effective in the short- and long-term, despite the added cost of such treatments compared to TAU, due to reductions in other forms of subsequent costly healthcare utilization. However, determining the amount of symptomatic benefit that merits additional treatment cost can be challenging. Further research aiming to maximize the benefits of these treatments while reducing cost – such as by utilizing skills group-only DBT treatment or PD-focused augmentations to TAU – may increase the cost-effectiveness of PD treatments.
4. **Research on "stepped-care" models**. Over the past decade, more emphasis has been placed on the importance of "stepped-care" models for psychotherapy (Paris 2013). These models aim to increase access to care for more patients by providing briefer, less intensive, easier trained, and/or easier to administer forms of psychotherapy for patients (often less severe) who may not definitively need more specialized treatments. GPM, for example, is one form of BPD treatment that is designed to be an effective "generalist" treatment more easily accessible to patients for whom specialized care (e.g., TFP, DBT) is cost prohibitive, geographically unavailable, or unnecessary due to lower symptom severity while still allowing referral to more intensive treatment services for more complex, symptomatic, or dysfunctional patients. Further research on and implementation of stepped-care models for PDs may increase access to care for many patients afflicted with these disorders.

Conclusion

In sum, personality disorders are prevalent, persistent, and often debilitating disorders for which the treatment literature remains underdeveloped. Given the complexity and interpersonal challenges of working with PD patients, therapists require some level of education or specialized

training in PD treatment in order to maximize their effectiveness with these patients. Research has identified several moderately effective treatments for specific PDs, with a focus on BPD, but further research and funding is needed for the range of PDs and to improve effectiveness of existing treatments. Although promising treatments exist, including effective components such as a flexible structure, a focus on interpersonal processes, a high treatment dosage, and an integration across approaches to psychotherapy, further research on PD treatments and principles of change is vital to enhance the well-being of individuals with PDs, their loved ones, and the societies in which they live.

Cross-References

- Antisocial Personality Disorder
- Avoidant Personality Disorder
- Borderline Personality Disorder
- Dependent Personality Disorder
- Evidence-Based Psychotherapy for Individuals with Personality Disorders
- Histrionic Personality Disorder
- Narcissistic Personality Disorder
- Obsessive-Compulsive Personality Disorder
- Paranoid Personality Disorder
- Personality Disorder Not Otherwise Specified (PDNOS)
- Schizoid Personality Disorder
- Schizotypal Personality Disorder

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