Promising Psychotherapies for Personality Disorders

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Objective: To provide a narrative review of recent research on the psychotherapeutic treatment of patients with personality disorders (PDs).

Method: We conducted PubMed and PsycINFO searches of recently published articles that reported on the treatment outcomes of psychotherapies for PDs. Our focus was on studies that used randomized controlled trial (RCT) methodology. The search period was from January 2006 to June 2009.

Results: The effectiveness of various psychotherapy treatment packages for PDs is well supported by favourable results from RCTs. Beneficial effects of psychotherapy included reduced symptomatology, improved social and interpersonal functioning, reduced frequency of maladaptive behaviours, and decreased hospitalization. Equivalent effects among the interventions we compared were common. Many of the treatments studied required only limited training by therapists. Most studies were focused on treating patients with borderline personality disorder (BPD). Some findings were suggestive of psychotherapy being cost-effective; however, few studies actually included formal cost analyses. Only one study included follow-up of treated patients beyond 1-year posttreatment.

Conclusions: There is strong support for the use of psychotherapy to treat patients with PDs. However, most of the evidence is limited to BPD. The findings of recent studies hold promise for training and practice. Future research should attend to identification of appropriate patient–treatment matches, elucidation of active treatment ingredients, and illumination of factors that are common among treatments that account for their equivalent effects.


Clinical Implications
- Patients with PDs can be treated effectively using various psychotherapy treatment packages, suggesting a better prognosis than is often assumed.
- From a best practices standpoint, psychotherapy appears to be the treatment of choice for PDs.
- Dissemination of effective treatment packages into training and practice realms appears promising as several tested treatments demanded only modest training periods.

Limitations
- There is limited research on treatments for disorders other than BPD.
- Long-term follow-up of treated patients remains scarce.
- Systematic economic evaluations of tested interventions are in short supply.

Key Words: psychotherapy, personality disorders, randomized controlled trials, narrative review
Considerable progress has been made in the psychotherapy of PDs.\textsuperscript{1-8} Once engendering a pervasive therapeutic nihilism, PDs are starting to be viewed as treatable with a much better prognosis than previously thought.\textsuperscript{9-13} Evidence from RCTs demonstrating the effectiveness of various forms of psychotherapy, coupled with findings from several longitudinal studies, suggests that such increased clinical optimism is warranted.\textsuperscript{11-14} This is encouraging, given that PDs are commonly encountered in nonclinical samples, with prevalence rates of 9% to 13%,\textsuperscript{15} and are among the most frequently treated conditions by psychiatrists in outpatient clinics.\textsuperscript{16} PDs also pose a serious public health problem, as they are associated with significant functional impairment, suicide risk, extensive treatment use, and worse outcomes in the treatment of depression.\textsuperscript{17}

Prospective longitudinal studies have found surprisingly high rates of remission for PDs.\textsuperscript{14,17,18} For instance, the McLean Study of Adult Development found that 88% of patients diagnosed with BPD severe enough to require hospitalization no longer met diagnostic criteria by the 10-year follow-up period, and of those whose symptoms remitted, only about 6% went on to have a recurrence.\textsuperscript{14-19} Similarly, in the Collaborative Longitudinal Personality Disorders Study,\textsuperscript{17} less than one-half of the patients followed still met criteria for a PD diagnosis after 2 years. Further, it has been estimated that patients with PDs receiving psychotherapy experience recovery 7 times faster, compared with the natural course of the illness.\textsuperscript{20} Taken together, these findings suggest that the traditional view of PDs espoused by the DSM as "enduring" conditions that remain "stable"\textsuperscript{18, p 685} in the long-term—a view which fosters pessimism about the potential for positive therapeutic outcomes—has not been borne out by empirical evidence.\textsuperscript{15}

This is especially true when we consider outcome data from RCTs of psychotherapy. There have been several systematic reviews\textsuperscript{1,12} and meta-analyses,\textsuperscript{20,23,24} including a Cochrane review,\textsuperscript{25} supporting the use of psychotherapy for PDs. This contrasts with the evidence for pharmacological interventions, which has been less encouraging.\textsuperscript{14,26} Although all of these reviews considered psychotherapy to be a promising treatment with favourable outcomes, they also cautioned that, given the small number of high-quality RCTs available (mainly before 2002), such a view was still preliminary. Nevertheless, the emergence of such an evidence base is a crucial advance in solidifying the place of psychotherapy as a treatment of choice for PDs.

Interestingly, a 2007 review found that between 2003 and 2006, twice as many RCTs of psychotherapy for PDs had been published than in the preceding 2 decades.\textsuperscript{8} Since then, several other, methodologically rigorous studies have been published. The goal of our paper is to provide an overview of these new research developments. Our primary focus is on therapies that have been tested by well-designed RCTs. In particular, we are interested in studies of psychotherapy that have been published in peer-reviewed journals that have been published in peer-reviewed journals during the past 3 years. To identify relevant studies, we conducted PubMed and PsycINFO searches dating from January 2006 to June 2009. Although we searched for studies on every PD, most available data pertain to BPD, which is reflected herein. It does not escape our attention that focusing solely on RCTs has limitations, the most obvious of which is overlooking other potentially relevant evaluative approaches, and privileging research that potentially may not generalize easily to clinical practice. The problem of generalizability has been identified as the bane of RCTs,\textsuperscript{2} as studies that include carefully selected patients who are treated by experts in academic centres providing services that are not generally available, do not seem directly relevant to everyday clinical care. From this vantage, the Cochrane Review of BPD concluded by stating a need for "real-world studies."\textsuperscript{25, p 2} These recent RCTs begin to address that need. Almost all of the studies reviewed here share features of both efficacy and effectiveness trials; for instance, most are conducted in everyday clinical settings, include participants with comorbid conditions common to PDs, and many provide treatment by nonexpert therapists.

Our review is intended as an updated guide to new psychotherapy treatment packages that may be relevant to clinicians involved in the care of patients with PDs. Although we are mainly concerned with new treatment packages, we also include recent findings from rigorous trials lending additional support to previously tested approaches such as DBT. All of these treatment packages derive from and are elaborations on established principles and practices; most have their roots in either psychodynamic or cognitive-behavioural approaches. None offers an entirely unique or novel

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**Abbreviations used in this article**

- ASPD: antisocial personality disorder
- AVPD: avoidant personality disorder
- BPD: borderline personality disorder
- CBT: cognitive-behavioural therapy
- DBT: dialectical behaviour therapy
- DDP: dynamic deconstructive psychotherapy
- DSM: Diagnostic and Statistical Manual of Mental Disorders
- GPM: general psychiatric management
- ISTDTP: intensive short-term dynamic psychotherapy
- MACT: manual-assisted cognitive therapy
- MBT: mentalization-based therapy
- PD: personality disorder
-RCT: randomized controlled trial
- SFT: schema-focused therapy
- ST: supportive therapy
- STEPPS: Systems Training for Emotional Predictability and Problem Solving
- TAU: treatment as usual
- TFP: transference-focused psychotherapy

**Modified Psychodynamic Approaches**

*Mentalization-Based Therapy.* MBT is a complex psychodynamic treatment that is rooted in attachment theory and draws on concepts from cognitive psychology. Bateman and Fonagy describe MBT as “a focus for therapy rather than a specific therapy in itself,” employing “a reiteration of well-known basic therapy practices such as support, empathy, exploration and challenge.” The focus of MBT is on enhancing mentalization.

Mentalization is the capacity to understand behaviour, one’s own and that of others, regarding underlying mental states (for example, thoughts and feelings). It is a mental process that involves recognizing how one’s perceptions of oneself and others are not equivalent to reality but are representations closely related to one’s thoughts, feelings, and desires. MBT seeks to enhance this reflective capacity, which is posited to be disrupted in patients with BPD—particularly in the context of relationships that activate their attachment system—and underlies their disturbed interpersonal relatedness. The integration of one’s experience of one’s own mind with the view presented by the therapist is a key component of MBT.

MBT was initially described as a psychoanalytically oriented treatment approach in the setting of partial hospitalization, a treatment package that consisted of both individual and group psychotherapy, and had proven effective in an 18-month RCT, compared with routine psychiatric care. Bateman and Fonagy recently reported impressive findings from an 8-year follow-up study of MBT demonstrating its long-term efficacy. This is the first long-term study following patients treated with an evidence-based psychotherapy. Patients (n = 41) who participated in the original trial were followed up 8 years after initial randomization (5 years after treatment completion). Patients treated with MBT exhibited substantial clinically and statistically significant differences from those treated with usual psychiatric care. They had far fewer suicide attempts (23% and 74%, respectively); reduced emergency department visits, hospitalizations, and use of mental health services; dramatically fewer medication prescriptions; and increased social, educational and vocational functioning. Perhaps most striking was that only 13% of patients treated with MBT still met criteria for BPD, compared with 87% of the control group. Despite these fairly remarkable improvements, patients in both groups continued to show impairment in general social function, albeit far less for those who received MBT; 46% of the MBT group had Global Assessment of Functioning scores above 60, compared with 11% of the TAU group.

*Transference-Focused Psychotherapy.* TFP is a structured, object relations approach, which emphasizes the integration of affect-laden mental representations of self and others that were originally derived through the internalization of attachment relationships with caregivers. Understanding how these internal representations begin activated in the here-and-now relationship with the therapist is a key part of therapy. In this way, negative affect states, particularly aggression, are gradually controlled by understanding them as they unfold in the context of the transference. TFP aims for full recovery, which encompasses reducing suicidality and self-injurious behaviour, improving behavioural control and affect regulation, and enhancing the ability to pursue gratifying relationships and meaningful life goals. It consists of twice-weekly individual therapy provided in the context of a clear contract and a consistent frame. TFP was the first experimental therapy for BPD to be tested under randomized conditions against another established treatment for BPD, that is, DBT.

In an RCT (n = 90) comparing DBT, TFP, and ST, patients in all 3 treatment groups showed significant, and generally equivalent improvement in social and global functioning, and significant decreases in depression and anxiety. Treatments were delivered in community mental health settings and included a broad range of patients with BPD—not just those exhibiting parasuicidal behaviour. While both TFP and DBT significantly improved suicidality, only patients in the TFP group demonstrated reductions in verbal assault, irritability, and direct assault. Overall, TFP led to improvement in a broader range of outcome measures (10/12) than DBT (5/12) and ST (6/12). A subsequent analysis of the trial data found that TFP resulted in significant improvements in attachment style (a change to more secure attachments), narrative coherence, and reflective functioning, which were not observed with DBT or ST.

**Preliminary Findings From Other Psychodynamic Approaches.** ISTDP has recently shown promise in a small RCT (n = 27) of mixed PDs. Patients were randomly allocated to either ISTDP or a minimal contact control condition. ISTDP encourages the awareness and experience of previously unconscious feelings associated with maintaining symptoms and dysfunction, while clarifying and challenging defences in collaboration with the patient. Patients and therapists meet on a weekly basis and mutually decide on when to terminate treatment (an average of 28 sessions). Patients treated with ISTDP not only experienced significant reductions in their symptoms and interpersonal problems, they also showed improvement in function, including doubling their overall work hours and rates of employment, and decreasing medication use (69% stopped all medications). By the end of the follow-up period, 86% of participants no longer met criteria for any PD, and treatment costs were calculated to have
and integrate polarized attributions about self and others, comorbid alcohol abuse. A significant proportion of these tested in an RCT of patients with fairly severe BPD and another manualized psychodynamic approach, DDP, was tested in an RCT of patients with fairly severe BPD and comorbid alcohol abuse. A significant proportion of these patients were also diagnosed with ASPD. DDP maintains a nonjudgmental and nondirective stance that focuses on helping patients identify and verbally express their emotions, construct coherent narratives of their interpersonal experiences, and integrate polarized attributions about self and others, without resorting to compensatory, maladaptive behaviours (for example, alcohol abuse) to alleviate painful affects. Participants were randomized to receive either 10 individual weekly sessions of DDP over 12 to 18 months (n = 15) or to TAU in the community (n = 15). Participants who received DDP showed significant improvement at 12 months in parasuicidal behaviour (decreasing from 73% of participants, pretreatment, to 30%), incidents of alcohol abuse (67% and 30%) and need for institutional care (67% and 10%), as well as reductions in overall medication prescriptions and measures of BPD pathology, depression, and dissociation. DDP was carried out by therapists who had very little prior psychotherapy training and was actually less time-intensive than routine community care.

**Modified CBT Approaches**

**Dialectical Behavioural Therapy.** DBT conceptualizes the core problem of BPD as a habitual breakdown of patients' cognitive, behavioural, and emotional regulation systems when they experience intense emotions. It is thought to facilitate change through the learning of emotion regulation skills in the validating environment of the treatment. DBT is a comprehensive treatment package that involves 4 modes of therapy: individual, in which the therapist oversees treatment integration and manages life-threatening behaviours and crises; group skills training, including mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness; skills generalization through telephone contact outside of normal therapy hours; and a consultation team designed to support therapists in working with difficult clients. Although DBT also comprises 4 stages of treatment, evidence from RCTs primarily pertains to the first stage, which involves eliminating dangerous and disruptive behaviours.

Since Linehan et al's seminal study of DBT almost 20 years ago, there have been several RCTs conducted by different research groups demonstrating its efficacy. The largest (n = 180) and most recent trial compared DBT with GPM, a standardized set of treatment practices derived from the American Psychiatric Association practice guidelines for the treatment of BPD. GPM consisted of weekly individual psychodynamic psychotherapy, case management, and medication management. Subjects were randomly assigned to 1 year of DBT or GPM. Both treatment groups showed improvements on most clinical outcomes, including reductions in frequency and severity of self-injurious behaviours; reduced BDP symptoms, general symptom distress, depression, and anger; lower rates of general health care use; and improved interpersonal functioning. There were no between-group differences on any of the outcome variables. Treatment retention (62%) was the same in the 2 treatments.

There was one other well-designed controlled trial of DBT for BPD published within our review period. In this study, DBT (n = 52) was compared with nonbehavioural therapy by community psychiatrists with expertise in the treatment of BPD (n = 49), a condition intended to control for nonspecific treatment effects of expert therapy. Participants in both groups showed substantial improvements, but those receiving DBT were about one-half as likely to attempt suicide (23%) as those treated by community experts (46%), to visit the emergency department for suicidal ideation (15.6% and 33.3%, respectively), or to drop out of treatment (25% and 59%, respectively). DBT-treated patients also had significantly lower rates of psychiatric hospitalization and use of crisis services. Although at 1-year follow-up there were no significant differences between treatment groups in the frequency of nonsuicidal acts of self-harm, subjects receiving DBT had a lower medical risk associated with their self-injurious behaviour. Subjects in both groups showed similar improvements on measures of depression, suicidal ideation, and reasons for living.

**Schema-Focused Therapy.** SFT is an integrative therapy that brings together elements of cognitive therapy, behavioural therapy, object relations, and gestalt therapy. It focuses on patients' maladaptive schemas or pervasive patterns of thinking, feeling, and behaving that are developed during childhood and are associated with problems in one's identity and sense of self, interpersonal functioning, and affect regulation. In this approach, BPD is thought to involve regression into early maladaptive modes of being that are tied to specific schemas and associated intense emotional states. Therapy involves recognition of self-perpetuating processes that maintain maladaptive schemas and render them resistant to change. Identifying and changing maladaptive schemas is the main focus of treatment. Changing schemas involves both cognitive and experiential work, including such approaches as limited adaptive reparenting (emphasizing acceptance and validation) and empathic confrontation. Maladaptive behaviours outside of therapy are also addressed. Recovery is the goal of treatment, and is achieved when maladaptive schemas no longer dominate patients' lives, allowing them to implement more adaptive coping skills.

A multicentre RCT comparing 3 years of outpatient, twice-weekly SFT to TFP in 86 patients with BPD found significant improvements in both groups, including reductions on all DSM-IV BPD symptoms, increased quality of life, and positive changes in personality, which were apparent after 1 year of treatment. Although after 3 years of treatment results generally favoured SFT, these findings have been contested by the consultant hired to provide supervision to...
the TFP therapists who felt that their adherence was less than adequate.46

SFT has been adapted into a group format, and its effectiveness was recently tested in a small RCT (n = 32) of female outpatients with fairly severe BPD.44 Patients in this study either received TAU, which largely comprised of weekly individual psychotherapy, or TAU plus SFT. SFT consisted of 30 weekly sessions during 8 months, and included components of emotional awareness training, psychoeducation, distress management, and schema change work. Patients receiving SFT improved significantly on a broad range of clinical measures of borderline psychopathology and showed increases in overall global functioning, while the control group either stayed the same or deteriorated. In addition, 94% of SFT patients no longer met criteria for BPD, compared with 8% receiving TAU—a positive effect that was maintained or increased after 6 months of follow-up. There was a remarkable 100% retention in the SFT groups. SFT has been shown to be cost-effective,47 and its adaptation into a group format will likely make it more so.

Other Trials of CBT. An RCT in a community setting investigated the value of combining up to 30 one-hour sessions of CBT, which aimed to correct maladaptive core beliefs and overdeveloped behavioural patterns that impair functioning, with TAU in 106 patients with BPD.48,49 Although both groups showed sustained and comparable improvement, results favoured the addition of CBT. Despite receiving an average of only 16 sessions of CBT by therapists with limited training during the course of 2 years, patients randomized to this group experienced a significant reduction in mean number of suicidal acts, levels of distress, dysfunctional thinking, and state anxiety, compared with TAU. The 2 groups did not differ in the number of psychiatric hospitalizations, emergency department visits, or depression ratings.

MACT is a short-term (6 sessions) individual therapy that incorporates elements of DBT (for example, emotion regulation strategies), CBT (for example, correcting negatively distorted thinking), and bibliotherapy. Weinberg et al50 adapted and tested this approach to address deliberate self-harm in 30 patients with BPD who were randomized to either receive MACT (n = 15) or TAU (n = 15). MACT patients attended all 6 sessions and exhibited significantly fewer acts of deliberate self-harm, compared with control subjects, with decreases both in frequency (93% less) and in severity at 6-month follow-up. These results diverge from a previous, larger RCT in which MACT was not found to improve outcomes, compared with TAU.51 However, 38% of patients randomized to MACT in this earlier study did not attend any sessions, but were included in the analyses. Also, in the study by Weinberg et al,50 MACT was provided as an adjunctive treatment, and deliberate acts of self-harm were distinguished from suicide attempts.

The efficacy of brief CBT (12 weeks) for reducing self-injurious behaviour22 was tested in an RCT of adolescents and young adults. Although participants in this study were not evaluated for the presence of a PD, their extensive maladaptive beliefs and repetitive acts of self-harm suggested high rates of personality pathology. CBT in addition to TAU not only significantly decreased repetitive acts of self-harm, compared with TAU alone, but also resulted in improved self-esteem and problem-solving ability, and reduced depression, anxiety, and suicidal ideation.

Connor et al53 carried out an RCT of CBT in violent men with ASPD. Participants were randomized to TAU plus CBT (n = 25) for either 6 or 12 months, or just TAU (n = 27). The CBT intervention focused on addressing beliefs about self and others, and behaviours that impair social and adaptive functioning. Decreased rates of verbal and physical aggression were reported by participants in both groups at 12-month follow-up, without a significant difference between the 2. However, this study was underpowered to detect between-group differences in clinically relevant outcomes. A nonsignificant trend was reported in the CBT intervention regarding reduced rates of harmful alcohol consumption, improved social functioning, and more positive beliefs about others.

A small RCT compared the effectiveness of CBT and brief dynamic therapy in the treatment of AVPD.54 Patients were randomized to either 20 weekly sessions of CBT (n = 21), brief dynamic therapy (n = 23), or a wait-list control. CBT was found to be more effective than brief dynamic therapy in ameliorating symptoms of AVPD. At follow-up, only 9% of patients in the CBT group and 36% of those receiving dynamic therapy still met diagnostic criteria for AVPD. Results favouring CBT in this trial differ from a previous 40-week RCT, which found both modalities to be equally effective in treating Cluster C PDs.55 As the authors point out, these are encouraging findings as AVPD has been shown to be persistent with a reported tendency to worsen over time.54

Treatment Approaches That Emphasize Psychoeducation

Systems Training for Emotional Predictability and Problem Solving. STEPPS is an adjunctive, multifaceted, 20-week treatment program designed to supplement patients’ ongoing care, be it psychotherapy or case management.56,57 STEPPS combines elements of CBT and skills training with a systems component, which actively involves people with whom the patient interacts regularly and has designated as their system members (family, significant others, and health care professionals). Systems members are provided education about BPD and how best to interact with the patient, while patients are encouraged to share their treatment notebooks with them. This systems approach is an innovative addition that aims to directly address some of the interpersonal problems that are a major feature of the disorder. Participants attend 2-hour weekly group seminars organized around learning specific emotional, cognitive, and behavioural self-management skills.

STEPPS was tested in a 20-week RCT with a 1-year follow-up in outpatients with BPD who either received STEPPS plus
TAU (n = 65) or just TAU (n = 59). Participants treated with STEPPS showed significantly greater improvement than control subjects on a broad range of clinical measures, including decreased levels of depression, negative affects and disturbed cognitions, reduced impulsivity, and better interpersonal and global functioning. Although there was a significant reduction in emergency department visits, there were no significant between-group differences for overall use of crisis services, suicide attempts, and self-harm. Given that other treatment programs (for example, DBT) have proven efficacious in reducing self-harming behaviour while demonstrating a much less impressive effect on such symptoms as depression, STEPPS, with its brief and easy to implement format, may serve a valuable, complementary role.12

Social Problem Solving Plus Psychoeducation. An important finding from prospective longitudinal studies of PDs is that problems in social relationships and social functioning are persistent, often despite substantial improvements in symptoms.18 Problem-solving therapy plus psychoeducation is a practical psychosocial treatment package intended to improve social competence by teaching patients with PDs how to identify solutions to problems in living.88

Huband et al58 conducted an RCT of problem-solving therapy for PDs. Patients in this study were randomly allocated to receive either 3 individual sessions of psychoeducation with 16 weeks of group-based problem-solving training complementing existing treatment (n = 87) or to a wait-list control (n = 89) in which they could still receive TAU. None of the study therapists (psychologists and psychiatric nurses) had previous training in the treatment program before a 2-day course attended as part of the trial. Participants who received problem-solving therapy plus psychoeducation showed significant improvement in social problem-solving ability, higher social functioning, and reduced anger expression, compared with control subjects. It is not known how much of the improvement can be attributed primarily to social problem-solving skills as even very brief psychoeducation has been shown to be of some benefit.59 Unfortunately, there were high dropout rates, with an overall completion rate of 48%.

Discussion
PDs are complex conditions that manifest in myriad ways. It is hard to imagine that a single therapeutic modality would work well for all patients, even if they carry the same diagnosis. The recent emergence of various empirically tested psychotherapeutic treatments is thus an important advance. Unfortunately, psychotherapy research on PDs other than BPD is lagging, and much work needs to be done to identify effective therapies for these patients.

Taken together, these studies speak to the importance of well-structured approaches within a coherent treatment framework that is understandable both to practitioners and to patients.10 The effective treatments we reviewed here share numerous common features. For instance, they incorporate psychoeducational, motivational, cognitive, and interpersonal components, albeit with differing degrees of emphasis, while affective and behavioural techniques are more variable.60 Given substantial differences across study parameters—outcome measures, duration of treatment, individual compared with group format, treatment setting, length of follow-up—comparisons about overall treatment effectiveness cannot easily be made. No psychotherapy treatment package can be said to be clearly superior.

Instead of pitting different therapies against each other, it may be more productive to consider how different approaches may work better for different patients, or how they can complement each other or be provided in a rational stepwise manner.12,66 Psychotherapy treatments such as STEPPS and social problem solving are intended to complement patients’ existing care, while others, such as SFT or TFP are designed as comprehensive treatments fostering the ambitious goal of recovery. It seems that where some therapies do less well, others succeed. For instance, STEPPS yields robust antidepressant effects, whereas DBT tends to underperform in this domain; and DBT significantly reduces self-injurious behaviour, while STEPPS does not.12

A stepwise or sequenced approach may consider different therapeutic interventions at different phases of patients’ illness.56,60 Livesley61 has proposed a general framework for integrating therapeutic approaches and techniques in a sequenced manner that conceptualizes patients’ personality pathology in stages, balancing treatment priorities (for example, safety) with amenability to intervention (for example, behavioural symptoms, compared with core traits), and emphasizes nonspecific components of therapy.

Except for its inclusion as a comparator in the RCT of TFP, there has been no systematic investigation of supportive psychotherapy in the treatment of PDs. This is unfortunate as it is arguably the most commonly practiced form of therapy.62 An RCT of supportive psychotherapy that is delivered in a well-defined framework aiming to maximize established common factors without adhering to any specific so-called brand techniques or elaborate theoretical orientation would be a welcome addition to the evidence base.

Given that PDs run a chronic course, longer-term treatment is generally assumed to be necessary. The most recently updated treatment guidelines for BPD from the National Institute for Health and Clinical Excellence in the United Kingdom even cautions against the use of brief psychological interventions.63 However, this seems at odds with recent findings suggesting that brief adjunctive interventions (for example, MACT, STEPPS, and problem-solving therapy) can have significant positive effects. Although there is an important signal that short-term therapies can have ameliorative effects, there is perhaps an even stronger signal that longer treatments with higher doses are of greater benefit. In several studies, significant improvement was only observed after 12 months of active treatment.
Despite deriving considerable symptomatic improvement from these various forms of psychotherapy, patients with PDs continue to show impairment in social functioning and diminished quality of life. This is consistent with prospective longitudinal studies demonstrating that remission of symptoms does not correspond with a return to normal functioning. Further, data from these longitudinal studies suggest that PDs can be better conceptualized as hybrid conditions that encompass both more stable personality traits (for example, related to temperament) and intermittently expressed dysfunctional symptomatic behaviours (for example, self-harm). Most therapies so far have primarily addressed these symptomatic behaviours. Psychotherapy research can make valuable contributions by developing strategies to enhance quality of life (rather than assuming it will improve as behavioural symptoms resolve) and to more directly address those enduring traits that persist even when the disorder remits.

Dismantling studies that isolate and test specific therapeutic interventions within more elaborate treatment packages are an important next step. Such an advance would likely lead to increased treatment efficiency and wider dissemination and availability of these treatments. A common criticism of DBT is that it is resource-intensive and expensive. While much less costly, dismantled forms of DBT are available (for instance, outpatient DBT skills groups), it is not known whether they share some of the same positive outcomes as the whole DBT package.

Another important avenue for future research concerns the investigation of common elements of various types of psychotherapy. Many authors have argued that the general finding of equivalent effects of different types of therapy implies that there are particular features that are common across these therapies that account for their effectiveness. Studies have suggested that a contextual model, which emphasizes common factors, is more consistent with the research evidence than is a model that posits specific therapeutic ingredients. Three particular sources that are believed to explain variability of outcome in psychological treatments are therapists, the therapeutic alliance, and expectations. Despite the persistent view that psychotherapy treatment is too expensive and not cost-effective, available data suggest otherwise. Recent studies have found that the costs of psychotherapy are not only offset by reductions in the use of other health care services, including hospitalizations, but also may result in savings. In addition to reduced direct costs to the medical system, there are decreases in indirect costs from increased productivity, and reduced absenteeism from work and imprisonment.

Although the evidence base for psychotherapy in the treatment of PDs has grown substantially during the past few years, we echo previous reviews in suggesting that our ability to draw confident conclusions is still hampered both by the small number of RCTs and by the methodological quality of available studies. Replication in larger, adequately powered studies is needed. Longer follow-up periods, such as in the MBT trial, would further increase confidence that treatment gains are maintained, as would the inclusion of conditions that control for the effects of natural recovery. Although much work still needs to be done, in light of the promising current evidence base for psychotherapy, pessimism about the treatment of PDs seems outdated.

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Résumé : Psychothérapies prometteuses pour les troubles de la personnalité

Objectif : Offrir une revue sommaire de la recherche récente sur le traitement psychothérapeutique des patients souffrant de troubles de la personnalité (TP).

Méthode : Nous avons recherché dans PubMed et PsycINFO des articles récemment publiés qui faisaient part des résultats de traitement de psychothérapie pour les TP. Nous avons mis l'accent sur les études qui utilisaient la méthodologie des essais randomisés contrôlés (ERC). La période de recherche s’étalait de janvier 2006 à juin 2009.

Résultats : L’efficacité de divers ensembles de traitements de psychothérapie pour les TP est bien soutenue par les résultats favorables des ERC. Les effets bénéfiques de la psychothérapie comprenaient une symptomatologie réduite, un meilleur fonctionnement social et interpersonnel, une fréquence réduite des comportements mésadaptés, et une hospitalisation réduite. Des effets équivalents parmi les interventions que nous avons comparées étaient communs. Nombre des traitements étudiés n’exigeaient qu’une formation limitée des thérapeutes. La plupart des études étaient axées sur le traitement des patients souffrant du trouble de la personnalité limite (TPL). Certains résultats suggéraient que la psychothérapie était rentable; cependant, peu d’études comprenaient vraiment des analyses formelles de coûts. Une seule étude comprenait un suivi de patients traités au-delà d’un an après le traitement.

Conclusions : Il y a un appui solide à l’utilisation de la psychothérapie pour traiter les patients souffrant de TP. Cependant, la plupart des données probantes se limitent au TPL. Les résultats des récentes études sont prometteurs pour la formation et la pratique. La future recherche devrait se préoccuper d’identifier les correspondances patient-traitement appropriées, d’élucider les ingrédients actifs du traitement, et de mettre en lumière les facteurs qui sont communs aux traitements et qui sont responsables des effets équivalents.