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Psychotherapy for Personality Disorders: Questions of Clinical Utility

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Running Head: CLINICAL UTILITY OF TREATMENTS FOR PERSONALITY DISORDERS

Psychotherapy for Personality Disorders: Questions of Clinical Utility

Abstract

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

Key-Words: Personality Disorders; Effectiveness; Clinical Utility; Psychotherapy

Psychotherapy of Personality Disorders: Questions of Clinical Utility

Introduction

Clinicians tend to find the therapeutic work with patients presenting with Personality Disorders (PDs) challenging and, for some, unrewarding (Lewis & Appleby, 1988; Paris, 2007). Patients with PDs are known to present with a number of interaction and regulation problems (Bender & Skodol, 2007; Gunderson & Links, 2008; Gunderson & Lyons-Ruth, 2008; Paris, 2007) which may provoke in therapists, among others, negative reactions, emotional retreat or feelings of helplessness (Lewis & Appleby, 1988). Personality disorders are also associated with a high societal burden of disease (Soeteman, Verheul, & Busschbach, 2008), along with individual suffering in terms of diminished quality of life on part of the patients, their families, and sometimes their clinicians. As such, despite accumulating outcome research (Budge, Moore, Del Re, Wampold, Baardseth & Nienhaus, 2013), some therapists in regular practice may continue to deliver sub-optimal treatments for patients with PDs. It is therefore necessary to bridge the gap between the results from outcome research, i.e., randomized controlled trials and meta-analyses, on the one hand and current clinical practice on the other. What is the actual clinical utility of different kinds of psychotherapy of PDs?

In the present paper, we will address this question in a synthetic fashion, for clinicians and administrators interested in implementing concrete treatment programs in their communities. Answering this question might be particularly important from a psychotherapy integration perspective (Clarkin, Cain & Livesley, 2015; Dimaggio, 2015; Livesley, Dimaggio, & Clarkin, 2016; Paris, 2015). In doing so, we will elaborate on specific questions related to clinical utility, implementation and optimal dosage of treatment (American Psychological Association, 2002).

Clinical utility of a treatment was defined by APA (2002, p. 1052) as “applicability, feasibility, and usefulness of the intervention in the local or specific setting where it is to be offered.” Beyond this general definition, clinical utility also includes questions of dosage, generalizability of a treatment whose efficacy has been demonstrated, cost-effectiveness and ease of implementation. It is also important to consider the ethical aspects of new psychotherapeutic treatments: liability and risk management are central in this regard. We aim to address three potential problems when implementing a therapy approach for patients with PDs, as non-exhaustive examples of questions related to clinical utility of psychological treatments. 1) Is the methodological basis of the initial studies sound? 2) Which specificities of the context of implementation are there, requiring adaptations of outpatient treatment to partial hospitalization, inpatient treatment, or short-term intervention? 3) Which are active ingredients in treatments for PDs, in particular from an integrative perspective? If these problems are addressed, clinical utility of a specific treatment should be optimized in a specific context. Our reflections aims at a general statement for all PDs; however, it might be ideal to formulate these problems and implications for each PD category separately, given their high heterogeneity.

Methodological basis of outcome studies for PDs

The question outcome has been addressed by six meta-analyses focusing on psychological treatments, so far, out of which three focused on PDs in general (Budge et al., 2013; Leichsenring & Leibing, 2003; Perry et al., 1999) and three on Borderline Personality Disorder (BPD) in particular (e.g., Binks et al., 2006; Stoffers et al., 2012); a number of treatment recommendations were also published (e.g., APA, 2001; Gaebel & Falkai, 2009; Hadjipavlou & Ogrodnickzuk, 2010; Leichsenring & Rabung, 2011; Sanislow & McGlashan, 1998; Verheul & Herbrink, 2007).

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

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

Among the ones most often studied, one can find the efficacious treatments for BPD, which are Dialectical-Behavior Therapy (e.g., Bohus et al., 2004; Linehan et al., 1993; Linehan

et al., 2006; McMain et al., 2009; Pasieczny & Connor, 2011; Pistorello et al., 2012; Priebe et al., 2012; Soler et al., 2009; Van den Bosch et al., 2002), Transference-Focused Psychotherapy (Clarkin et al., 2007; Doering et al., 2010; Giesen-Bloo et al., 2006), Mentalization-Based Treatment (Bateman & Fonagy, 1999, 2008), Schema-focused Therapy (Bamelis et al., 2014; Farrell et al., 2009; Giesen-Bloo et al., 2006; Jacob et al., 2010) and Systems Training for Emotional Predictability and Problem Solving (Blum et al., 2008).

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

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

effects may be attributable to a number of methodological problems of the initial studies, including the researcher’s allegiance. Researcher's allegiance is well-described as one of the most influential effects on results in efficacy studies (Luborsky, Diguer, Seligman, Rosenthal, Krause, Johnson, Halperin, Bishop, Berman, & Schweizer, 1999) and denotes the preference of a research team who conducts a study for a specific treatment model (and thus a non-preference for the alternative treatment model). We may add that another characteristic of an outcome study is the quality of ratings of the main outcome variable: raters who are non-blind to the treatment condition (i.e., who know the condition a specific patient is in) tend to report higher between-group effects when compared to blind raters unknowledgeable of the treatment condition. Finally, differences in therapist adherence - the degree to which therapists actually do what the manual prescribes (and hold back from doing what the manual prohibites) - may be another source for differences found between active treatments. For these reasons, there might here and there be an individual study which reports between-condition effects for two active treatments: these results should be interpreted with great caution. Similar comments may be true for studies on efficacy for mediation. In the domain of psychotherapy for PDs, Giesen-Bloo, van Dyck, Spinhoven, van Tilburg, Dirksen, van Asselt, Kremers, Nadort and Arntz (2006) have found differences in efficacy between two effective long-term treatments: transference-focused (TFP) and schema-focused psychotherapy, favoring the latter. With regard to this study, Yeomans (2007) highlighted possible problems with therapist adherence in the TFP condition, whereas Levy, Meehan and Yeomans (2012, p. 145) discussed one of the “most potent methodological choices that results in allegiance effects”: the pre-selection of therapists who differ in skillfulness favoring the condition preferred by the researchers. When taking into account all these possible influences and when adequately interpreting findings of the literature as a whole, one can

conclude, with some caution, that active and PD-specific treatments tend to be equally effective. It is important to note that not all treatments present evidence for all categories of PDs – in fact, to our knowledge, no treatment presents evidence for all DSM-5 PD categories –: this does not mean they are ineffective for specific understudied forms of PDs. Therefore, all PD-specific *bona fide* treatments merit to be implemented, when done by skillful therapists. Skillfulness may be assured by sufficiently intense training of the therapists, which involves for patients with PDs case supervision based on tape-reviewing of the actual patient-therapist interaction. Manuals which were developed may also facilitate the self-monitoring by the therapists themselves, complementing individual case supervision.

Specificities related to context of implementation

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

Partial hospitalization, or day hospital treatment, involves structured day activities over a period of time during which the patient spends the evenings and nights elsewhere. A recent clinical review and recommendation (Verheul & Herbrink, 2007) suggests, taking the empirical literature together, that Cluster A (with some severe forms of Cluster B) PDs responds well to long-term day hospital treatment, whereas Cluster C and remaining (less severe forms of) Cluster B PDs benefit rather from short-term treatment frames. It is advised that partial hospitalization is optimally followed by an outpatient psychotherapy treatment program which helps to deepen and generalize the effects of the initial day hospital treatment (Verheul et al., 2007; Gunderson & Links, 2008). Inpatient treatment of PDs generally represents long-term psychodynamically-informed milieu-based treatment involving 6 to 12 months of hospitalization. Such intervention

tends to be effective for any PDs (see the review by Verheul & Herbrink, 2007). Shorter, multi-modal and specifically intense, treatment frames have also shown their effectiveness (e.g., Sollberger, Gremaud-Heitz, Riemenschneider, Agarwalla, Benecke, Schwald, Küchenhoff, Walter, & Dammann, 2014). Similar to the day-hospital option, it is generally advised to plan a follow-up outpatient psychotherapy program after an inpatient treatment for PDs.

When implementing a specific treatment approach in a community, the question of dosage is central. For how long and how intense should the treatment be? Based on four outpatient studies at the time, the meta-analysis by Perry, Banon and Ianni (1999) estimated that 25% of patients with PD recovered after 5 months of treatment, 50% after 15 months (equivalent to 90 sessions) and 75% after 26 months (encompassing over 200 therapy sessions). Such progression over time is slightly smaller than found in other patients, and as described in the seminal contribution by Howard, Kopta, Krause, Merton and Orlinsky (1986). The latter describes a negatively accelerated curve, when relating dosage to therapy outcome over time. It needs to be noted that without appropriate controls, dose-effect relationships may not be attributable to the specific treatment approach, but may be the result of a spontaneous remission. Leichsenring and Rabung (2011) have reported that the rate of recovery for PDs might differ between therapy approaches, with an optimum of around 100 sessions for psychodynamic psychotherapies for PD to be effective, which might be shorter for cognitive therapies, although it is not clear if the detailed quality of recovery is comparable between these treatment approaches. In addition, several authors recommend highly intense treatments, for example twice weekly outpatient psychotherapy (e.g., Yeomans, Clarkin, & Kernberg, 2002) or intense multimodal inpatient treatment (Gaebel & Falkai, 2009). So far, these considerations on dosage include quite different forms of therapy and do not specify the severity of patients at intake.

Recently, researchers have demonstrated for specific target symptom short-term changes across treatment models: first effects were observed after three to 6 months of treatment for patients with borderline personality disorder (Blum et al., 2008; Kramer, Kolly, Berthoud, Keller, Preisig, Caspar, Berger, de Roten, Marquet, & Despland, 2014; Palmer, Davidson, Tyrer, Gumley, Tata, Norrie, Murray & Seivewright, 2008; Stanley, Brodsky, Nelson, & Dulit, 2007). Therefore, more studies are necessary on treatment dosage to determine optimal levels of care for each PD.

Effective ingredients: the therapist and the therapeutic relationship

While the specific technique matters very little, as shown by a number of psychotherapy studies (see Budge et al., 2013), research has suggested the relevance of the so-called common factors in psychotherapy (e.g., empathy, therapeutic alliance, group cohesiveness; Smith, Barrett, Benjamin, & Barber, 2006; Wampold, 2001). There are several caveats when treating patients with PD. Firstly, it needs to be noted that, maybe contrary to clinical intuition, the therapeutic alliance in treatments for patients with BPD tends to be only weakly related with the therapeutic outcome at the end of treatment, according a recent meta-analysis (Scala, Ellison, & Levy, 2014). Secondly, the common factor concept does not specify concretely how the therapist should go about to facilitate such common processes in the therapy room (Stiles, 2013). Thirdly, it might be particularly difficult for a therapist facing a patient with PD to implement such common factors, related to the challenging moment-by-moment interpersonal and intrapsychological fluctuations of mental states observed in these patients (Levy, Beeney, Wasserman, & Clarkin, 2010).

There are specific clinical procedures facilitating the increase of the quality of the collaboration which are adapted to the requirements of patients with PDs and take into account

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

The person of the therapist is, last but not least, central in the treatment with patients presenting with PDs. It is noteworthy that most trials that have studied treatments for PDs did not take into account the therapist variable, even though a large literature exists on the moderating effect of the therapist on outcome (Baldwin & Imel, 2013). From a clinical perspective, Fernandez-Alvarez, Clarkin, Salgueiro, & Critchfield (2006, p. 215) have summarized that the effective therapist facing a patient with PD should (a) be open-minded, flexible and creative in the treatment approach, (b) be comfortable with long-term treatments requiring emotionally intense relationships, (c) be tolerant of his/her own negative affects, (d) have patience and (e) have a specific training in the treatment of PDs. The therapist needs therefore specific skills to manage his/her own inner (i.e., counter-transferential) reactions to the interactions with these patients, in order to be able to intervene effectively (Livesley, Dimaggio, & Clarkin, 2016). We

believe, that this can be achieved, again, by thorough training in the clinical models and procedures. If training seems important, accurate research on if training has the expected impact of the quality of intervention facing patients with PDs is still lacking. Recently, Keuroghlian, Palmer, Choi-Kain, Borba, Links and Gunderson (2015) have published a report on a one-day introductory class into psychiatric treatment for patients with borderline personality disorder. Only after this brief exposure, the participants reported more hopefulness in the treatment of these patients and increased levels of trust in their therapeutic skills, in addition, their image of these patients have changed towards a more nuanced view of a person with low self-esteem in need of care. Definitely, more research is needed on the impact of training for the quality of intervention facing these patients, in particular longer training programs.

Conclusions

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

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

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

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