The treatment of personality disorder: Where are we? Where do we go from here? Where do we want to end up?

The rationale for integrated treatment

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WHERE ARE WE?

1. What works?
2. What changes?
3. Why does change occur?
4. What are the limitations of current therapies?

I. What works?

Just about everything:

- Specialized therapies for personality disorder
- Good clinical care
- Supportive therapy

Effective Treatments for BPD

Dialectic behavior therapy (Linehan, 1993): DBT

- Linehan et al., (1993)

Transference focused therapy (Clarkin et al., 1999, 2006): TFT

- Clarkin et al., (2007); Levy et al., (2006); Doering et al., (2010)

Schema focused therapy (Young et al, 2003): SFT

- Giessen-Bloo et al., (2006)

Mentalizing based therapy (MBT)

- Bateman & Fonagy, (1999, 2001)

Systems Training for Predictability and Problem Solving: STEPPS (Blum et al., 2008)

Cognitive analytic therapy (Ryle, 1997)

- Chanen et al., (2008)

Outcome Across Specialized Therapies

- Outcome does not appear to differ in clinically significant ways across the specialized therapies for borderline personality disorder:
  - Bartak et al., 2007; Budge, Moore, Del Re, Wampold, Baardseth, & Nienhaus, 2014; Leichsenring & Leibing, 2003; Leichsenring, Leibing, Kruse, New, & Leweke, 2011; Mulder & Chanen, 2013
- Comparison of SFT and TFP (Giesen-Bloo et al, 2006) showed that SFT had fewer dropouts and better outcomes but questions have been raised about whether the two treatments were delivered in comparable ways (Yeomans, 2007)

Comparisons: Specific Treatments versus Good Psychiatric Care

McMain et al., (2009): DBT versus general psychiatric management

- Combination of psychodynamically-informed therapy and symptom-targeted medication based on APA guidelines
- No differences in outcome

Bateman & Fonagy, (2009): MBT versus structured clinical management

- Outcome was similar
- Problems decreased faster with MBT

Chanen et al., (2008): CAT versus manualized good clinical care

- No differences in outcome

Specialized Versus Supportive Therapy

Clarkin, Levy, Lenzenweger, and Kernberg (2007):

- Comparison of TFP, DBT, and supportive dynamic treatment

Cottaux et al., (2009)

- Short-term cognitive therapy versus Rogerian supportive therapy
- Results slightly better for cognitive therapy
- Both treatments produced poor outcomes

Jorgensen et al., (2012, 2014):

- Mentalizing-based therapy versus psychodynamic supportive therapy

II. What changes?

Limited assessment of specific features

Outcome changes:

- Symptomatic improvement, reduced self-harm and suicidality, decreased hospital admissions including those for medical problems

Residual Problems:

- Substantial problems remain following treatment (McMain et al., 2009; Kröger et al., 2013)
- Overall functioning and quality of life remain poor (Cameron et al., 2014)
- Core interpersonal problems and self-identity problems remain

The findings are consistent with longitudinal studies

- Although symptoms improve over time, social adjustment remains poor

III. Why does change occur?

Little attention has been given to until recently to change mechanisms

Similarity in outcome across specialized therapies, good clinical care, and supportive therapy points to the importance of change mechanisms common to all therapies

The joint Task Force of the Society for Clinical Psychology (Division 12 of the American Psychological Association) and the North American Society for Psychotherapy Research documented the importance of common mechanisms based on qualitative analyses of the empirical literature (Castonguay & Beutler, 2006)

These findings are consistent with studies showing that outcome for most mental disorders is similar across therapies (e.g., Beutler, 1991; Castonguay & Beutler, 2006, Luborsky, Singer, & Luborsky, 1975)

Common Change Mechanisms

The Task Force documented the importance of:

- A good working alliance
- Careful attention to repairing ruptures to the alliance using an empathic and flexible approach
- Therapist attitude of caring, warmth, empathy, positive regard, congruence, and authenticity
- Collaborative agreement between patient and therapist on treatment goals
- Patient-therapist collaboration in working toward goals
- Relatively high level of therapist activity

Smith, Barrett, Benjamin, & Barber, 2006

Critchfield & Benjamin, 2006

Empirical Studies of Change Mechanisms (1)

The few studies conducted suggest that changes in emotional dysregulation is central to the change process:

- Improved emotion dysregulation mediated changes deliberate self-harm in patients with BPD (Gratz, Levy, & Tull, 2012)
- Changes in emotional dysregulation mediated improvements in the cognitive and emotional features of BPD and predicted improvements in deliberate self-injury at 9-month follow-up.
  - Improved emotional dysregulation did not lead to decreased deliberate self-injury during treatment.
  - Rather, improved emotional regulation seemed to reduce cognitive and emotional impairments that subsequently led to decreased deliberate self-injury (Gratz, Bardeen, Levy, Dixon-Gordon, & Tull, 2015)

Empirical Studies of Change Mechanisms (2)

- Specific changes in emotion and cognitive problem-solving processes predict treatment outcome (McMain et al., 2013):
  - Improved emotional balance (an increase of positive to negative emotions) and problem solving were associated with reductions in general symptom distress and improved interpersonal functioning
  - With emotional balance (but not problem solving) the effect on outcome measures remained after controlling for the effect of the treatment alliance suggesting that this factor has an independent effect on outcome

Clinical Implications of Empirical Studies

Research suggests that improved emotional dysregulation is central to outcome

Attention should be given not only to how emotional dysregulation affects emotional expression but how it affects cognitive functioning

Based on empirical findings and clinical observation, it seems reasonable to hypothesize that improved emotional regulation is a necessary precursor to changes in interpersonal and self pathology

IV. Limitations of Current Treatments

1. Dropout is high:
   - Up to 60% based on intention to treat; 22 to 46% of those treated
   - Dropout is important:
     - Subsequent hospital admissions are twice as high after one year (Karterud et al., 2003)
     - Global functioning, severity and interpersonal functioning significantly lower 5 years later (Karterud et al., 2003)
2. Treatments do not address patient heterogeneity:
   - One method fits all approach
   - Severity ignored yet severity predicts outcome better that DSM diagnoses (Crawford et al (2011)
   - Patient needs are more complex and varied than current therapies suggest
3. Current treatments are not comprehensive

Conceptual Limitations of Contemporary Therapies

Most theories offer one-dimensional explanations of personality disorder:

- Emotional dysregulation
- Impaired mentalizing
- Maladaptive cognitive processes or schema
- Dysfunctional object relationships

Each therapy focuses primarily on the assumed impairment

Personality pathology includes all these impairments

Limitation of Outcome Studies

Primary focus on borderline personality disorder initially raised questions about generalizability to other personality disorders:

- Emerging evidence suggests that some therapies are effective with other disorders:
  - SFT (Bamelis, Evers, Spinhoven, & Arntz, 2014)
  - CAT, (Clarke, Thomas, & James, 2013)
  - CBTpd (Davidson et al., 2006 a, b; Davidson et al., 2009)

Generalizability of findings is limited by the comparatively small sample sizes of many studies (Davidson et al., 2006b)

Studies often incorporate a limited array of outcome variables

Questionable clinical value of some outcome measures e.g., number of patients who show “remission” defined by failure to meet diagnostic thresholds

Summary

Treatment is effective

Out is similar across therapies

Current therapies have substantial

Current treatment have conceptual and practical limitations

It appears that what is important is to adopt a structured approach and build a collaborative and trusting relationship that enables patients to construct a coherent understanding of themselves and their problems and allows them to become open to the idea of change

Where do we go from here?

NEED FOR A TRANS-THEORETICAL AND TRANS-DIAGNOSTIC APPROACH TO TREATMENT

Trans-Theoretical Treatment

Integrated treatment model

Take what works from all effective therapies without regard to their theoretical orientation but leave the theory behind

Tailor treatment to the problems and psychopathology of individual patients

Pathways to Integration

1. Common factors
2. Technical eclecticism
3. Theoretical integration

(Arkowitz, 1989; Norcross & Greencavage, 1989; Nelson et al., 2012; Norcross & Newman, 1992; Stricker, 2011)

1. Common Factors

Integration based on principles of change common to all therapies

Common change mechanisms account for a large part of outcome

These principles to establish the basic structure of treatment

Common Factors

Procedural

- Structure

Relational

- Establish a collaborative alliance
- Maintain a consistent treatment process
- Ensure a validating treatment process

Instrumental

- Promote self-knowledge and self-reflection
- Build motivation

2. Technical Eclecticism

Interventions selected from all treatment models without adopting their associated theories

Most experienced clinicians show some technical eclecticism

Many clinicians use assimilative integration – they adopt a single orientation but use methods from other orientations (Nelson et al., 2012)

Interventions selected based on evidence of efficacy and patient need

Necessary to cover all domains of personality pathology

3. Theoretical Integration

Integration of the major components of two or more therapies to create a more effective model

Goal is to integrate underlying theories of psychopathology and change

Given the modest state of theory development, theoretical integration is probably a distant hope

Summary

Common factors form the basis for integration

- Treatment should:
  - Be organized around common factors
  - Optimize common factors

Technical eclecticism is necessary

- Treat all domains of psychopathology
- Accommodate the heterogeneity of personality pathology

Theoretical integration

- Not possible currently
- Ultimate goal

Trans-Diagnostic Approach

Contemporary therapies tend to focus on specific diagnoses

Current diagnoses are contrived constructs

- Product of committee deliberations
- Unrelated to basic biological or psychological mechanisms

Limited benefits from continuing to develop treatments for specific diagnoses

Alternative approach:

- Decompose personality disorder into domains of impairment that cut across current diagnostic constructs (Livesley & Clarkin, 2015; Clarkin & Livesley, 2015)
- Identify interventions to treat each domain based on efficacy and relevance

Diagnostic and Assessment Relevant to Trans-theoretical and Trans-diagnostic Treatment

Diagnosis of personality disorder and assessment of severity

- Self pathology
- Interpersonal pathology

Assessment of traits and trait constellations

- Emotional-interpersonal
- Dissocial
- Social avoidance

Assessment of domains of psychopathology:

- Symptoms
- Regulation and modulation
- Interpersonal
- Self

Livesley & Clarkin, (2015); Clarkin & Livesley, (2015)

Domains of Psychopathology

Extensive within-individual heterogeneity in problems and psychopathology

More helpful to think about domains of impairment than categorical diagnoses

Outcome shows evidence of domain specificity (Piper & Joyce, 2001): interventions that work for one domain do not necessarily work for another

Domains and Change in Personality Pathology

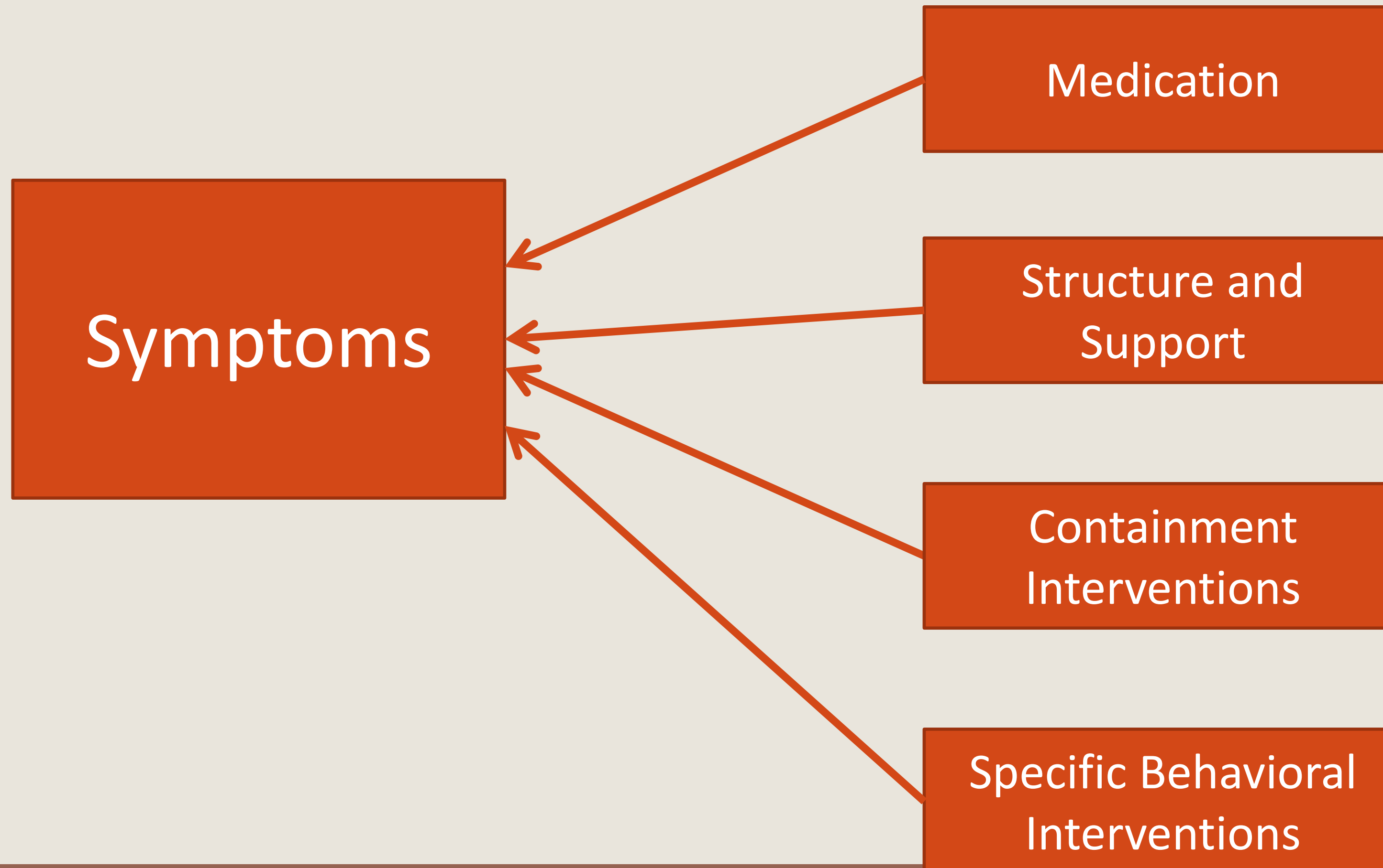
Symptoms

Regulation and Modulation

Interpersonal

Self/Identity

Domains and Intervention Modules



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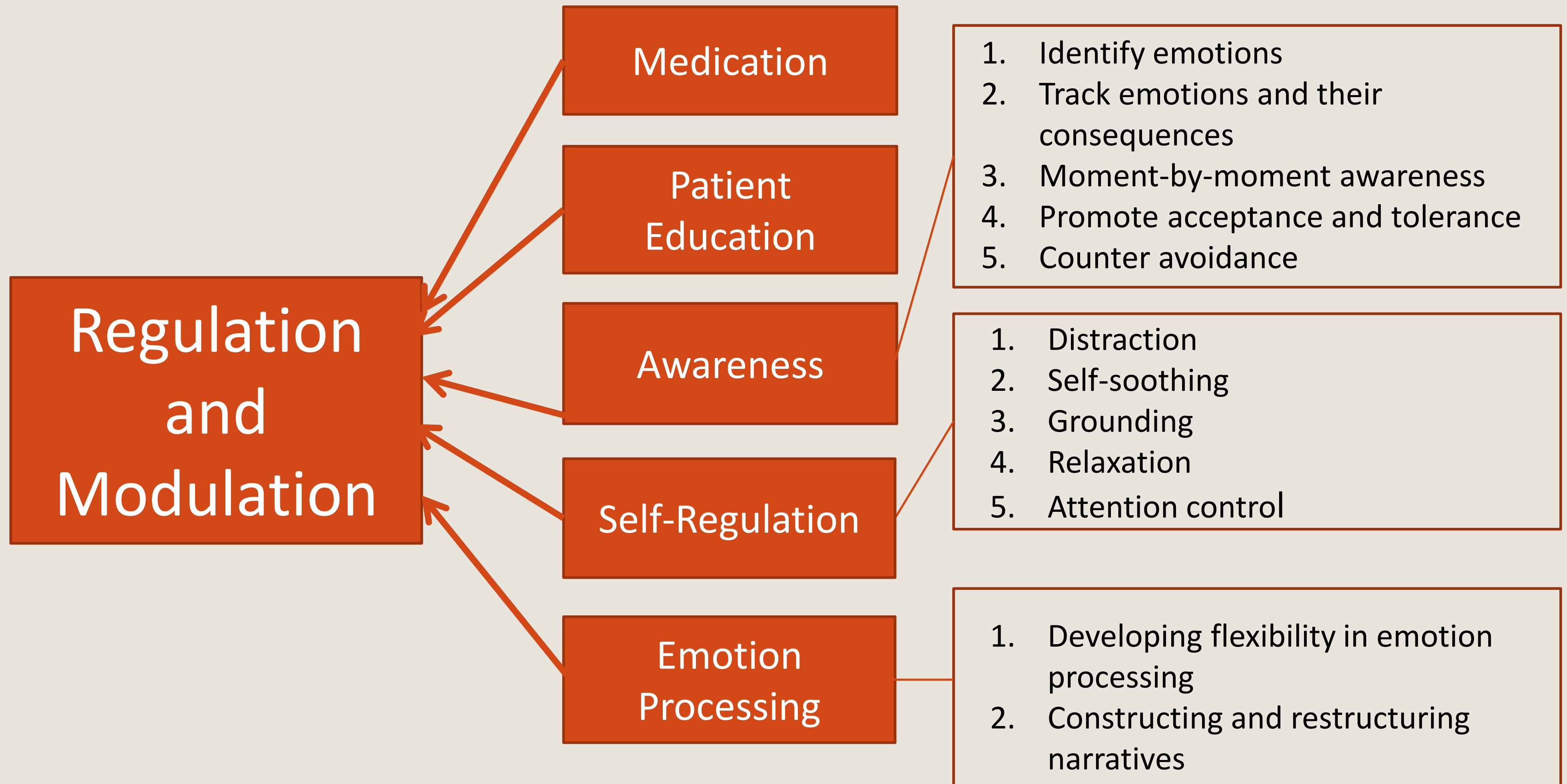

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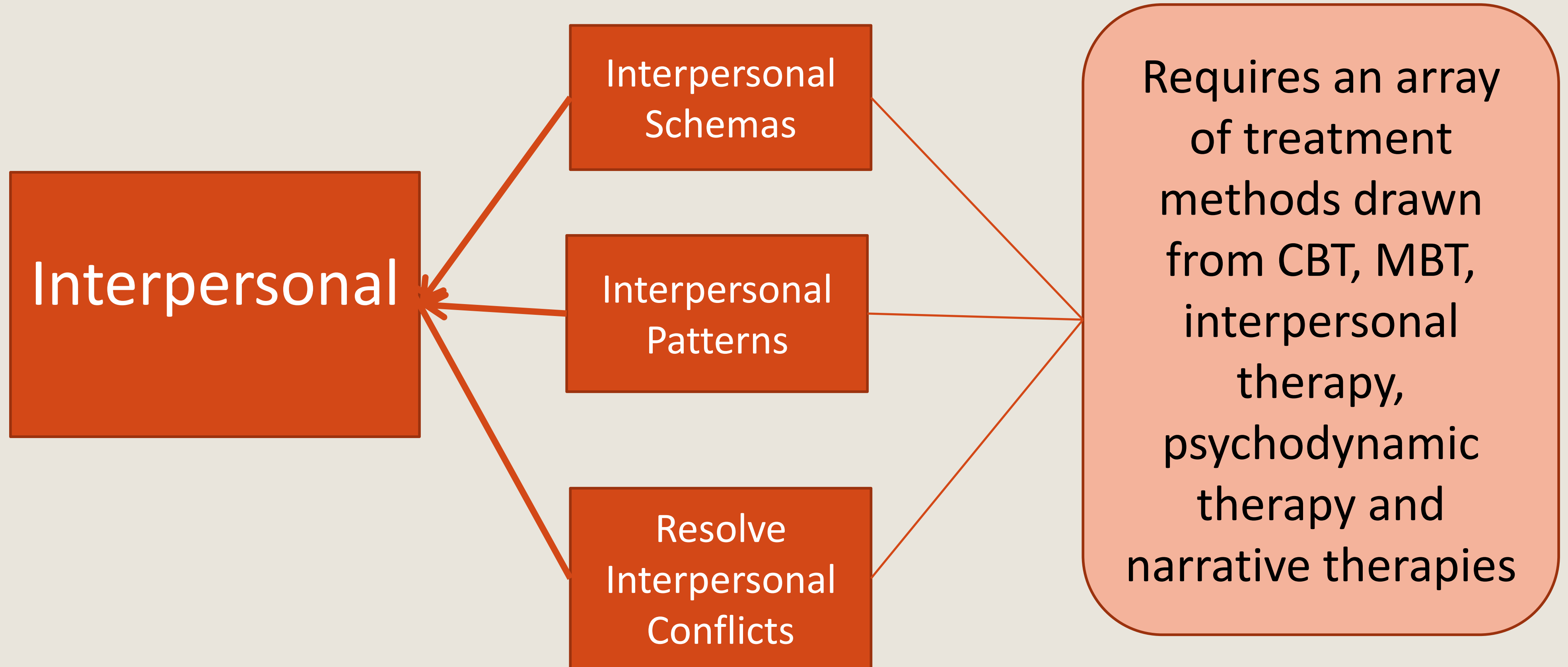

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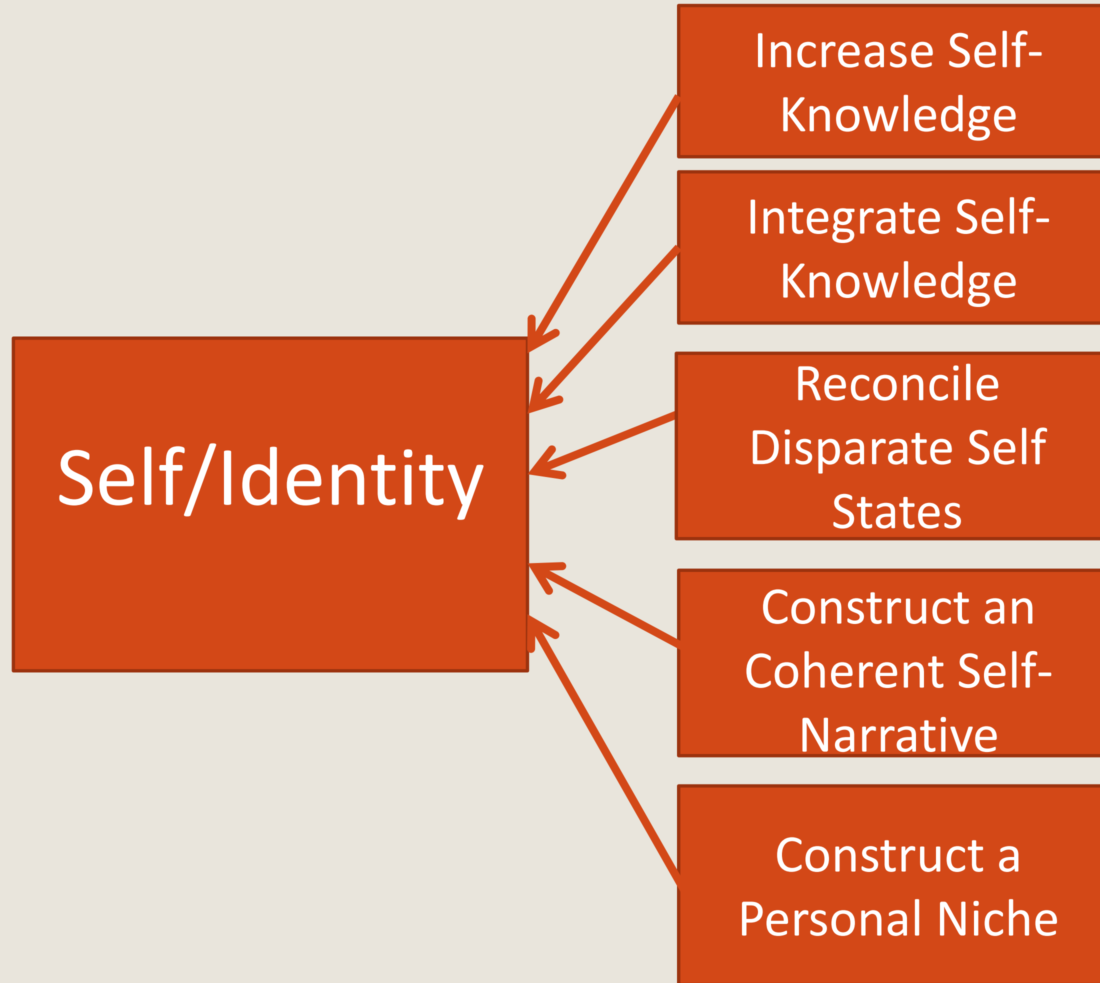

Where do we want to end up?

THEORETICAL INTEGRATION AS THE ULTIMATE GOAL

Theoretical Integration

Mechanism-based approach to diagnosis and treatment

Mechanisms conceptualized as neuro-psychological structures:

Conceptual pluralism:

- Mechanisms described and conceptualized from different perspectives
- Treatment based on most effective interventions for treating dysfunctions in specific personality mechanisms

Personality disorder is primarily a psychological disorder:

- Psychological level as the primary level of explanation and intervention

Phases in the Development of Treatments for Personality Disorder

Phase	Description
Phase I: pre-1990	• Few clinical trials limited to modest evaluation of the treatment of psychopathy • Psychoanalytically-based therapies • Milieu therapy largely in forensic settings
Phase II: 1990 to the present	• Proliferation of treatments mostly for BPD • RCTs demonstrating efficacy of multiple therapies • Specialized therapies are not better than “good clinical” or supportive therapy
Phase III: Current situation	• Need to re-evaluate treatment strategies • Emergence of integrated and eclectic approaches
Phase IV: Long-term objective	• Mechanism-focused treatment

Be open to everything but attached to nothing!