Schema therapy is an effective treatment for avoidant, dependent and obsessive–compulsive personality disorders

Christopher J Hopwood, Katherine M Thomas

Department of Psychology, Michigan State University, East Lansing, Michigan, USA
Correspondence to Christopher J Hopwood, hopwood2@msu.edu

WHAT IS ALREADY KNOWN ON THIS TOPIC?

It is difficult to evaluate the effectiveness of personality disorder (PD) assessment and treatment because of unclear boundaries between PDs as conceptualised in the current taxonomy[1] and similarly unclear boundaries between concepts of treatments across orientations and manuals.[2] Nevertheless, there has been consistent evidence that focused psychosocial interventions lead to symptom reductions in borderline PD.[3] Considerably, less is known about how to best treat non-borderline PDs.

WHAT DOES THIS PAPER ADD?

- In a large, multisite study, Bamelis and colleagues showed that schema therapy is more effective than clarification-based therapy or treatment as usual in terms of reducing dropout and interview-based PD symptoms and increasing interview-rated functioning for a sample of individuals with a range of primary PDs.
- This study also highlights how different therapy training protocols can lead to differences in patient dropout and outcome. Specifically, experiential training was generally more effective than lecture-based training in reducing patient distress and dropout.

LIMITATIONS

- There was little evidence that schema therapy was more useful for improving self-reported functioning or longer term outcomes, suggesting that patients in the study did not experience differential effects of treatments from their perspective.
- The study is based on a taxonomic system for classifying PDs that is known to be psychometrically problematic.[1]
- Ostensible differences between the therapeutic packages—two of which are likely rare in applied practice with PDs—are not well articulated. Instead, as is common in treatment research, treatments are assumed to be different because of different stated rationales or manualised procedures, even though those differences are not measured or manipulated systematically.

WHAT NEXT IN RESEARCH?

Improved models of the nature of personality pathology, such as is offered in Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition Section III, will improve this kind of research by providing more reliable and valid targets for intervention. For example, this model may promote treatment procedures that target the specific traits that trouble patients, rather than empirically questionable categories that combine traits that do not run together empirically.[4] Similar work is needed with respect to quantifying differences between treatment packages, which often tend to perform similarly as in the current study, perhaps because they utilise common mechanisms.[5]

COULD THESE RESULTS CHANGE YOUR PRACTICES AND WHY?

No. This research is consistent with previous studies suggesting that therapeutic approaches to PD are most likely to be effective when they are thoughtful, well planned and evidence based. The specific superiority of schema therapy in this regard is unclear because of questions about the validity of the comparison treatments, potential allegiance effects and the lack of generalisation of study results across outcome measures. Nevertheless, it is encouraging that the effects of a well-conceived treatment extend beyond borderline PDs, and overall this research emphasises the utility of evidence-based treatments for personality pathology. We will continue to use evidence-based treatments, which include schema-focused therapy, but this research does not compel us to prefer that approach specifically.

Competing interests None.

doi:10.1136/eb-2014-101858

REFERENCES

1. **Krueger RF,** Eaton N. Personality traits and the classification of mental disorders: toward a more complete integration in DSM 5 and an empirical model of psychopathology. *Personal Disord* 2010;**1**:97–118.
2. **Hopwood CJ,** Swenson CM, Bateman AW, *et al*. Approaches to psychotherapy for borderline personality: demonstrations by four master clinicians. *Personal Disord* 2013;**105**:108–16.
3. **Bateman AW.** Treating borderline personality disorder in clinical practice. *AM J Psychiatry* 2012;**169**:560–3.
4. **Livesley WJ.** Integrated treatment: a conceptual framework for an evidence-based approach to the treatment of personality disorder. *J Personal Disord* 2012;**26**:17–42.
5. **Imel ZE,** Wampold BE, Miller SD, *et al*. Distinctions without a difference: direct comparisons of psychotherapies for alcohol use disorders. *Psychol Addict Behav* 2008;**22**:533–43.

Commentary on

ABSTRACT FROM Bamelis LL, Evers SM, Spinhoven P, *et al*. Results of a multicenter randomized controlled trial of the clinical effectiveness of schema therapy for personality disorders. *AM J Psychiatry* 2014;171:305–22.

Patients/participants Three hundred and twenty-three adults (aged 18–65 years) with at least one of the following personality disorders: cluster C (avoidant, dependent and obsessive–compulsive disorders), histrionic, narcissistic and paranoid (Structured Clinical Interview for Diagnostic and Statistical Manual of Mental Disorders Fourth Edition (DSM-IV) Axis II Personality Disorders (SCID II)). Exclusions: antisocial, schizotypal, schizoid or borderline personality disorder; psychosis or bipolar disorder; IQ less than 80 and immediate suicide risk or substance abuse requiring detoxification.

Setting Twelve Dutch mental health institutes; May 2006–January 2011.

Intervention Schema therapy for 50 sessions (n=147), clarification-oriented psychotherapy (COP; n=41) or treatment as usual (TAU; n=135). Schema therapy is an integrative psychotherapy combining cognitive, experiential, behavioural and interpersonal techniques which includes extensive processing of negative childhood experiences. COP helps to discover dysfunctional patterns, improve their insight and make functional changes.

Comparison TAU, which mostly involved psychological therapy, ranging from supportive low-frequency contact to advanced psychotherapy.

Patient follow-up Assessments at 6, 12, 18, 24 and 36 months. There was high loss to follow-up across all groups: 77 of 147 participants (53%)

completed schema therapy (29% discontinued and 19% lost to follow-up); 25 of 41 (61%) completed COP (22% discontinued and 17% lost to follow-up); and 32 of 135 (24%) completed TAU (44% discontinued and 33% lost to follow-up).

Analysis was by intention to treat; dropout was analysed using survival analysis controlling for baseline severity and therapist cohort (trained primarily by lectures or exercises), and with mixed logistic regression. For depression and anxiety outcomes, multiple imputation and logistic regression were used.

Allocation Nine centres randomised to schema therapy or TAU; in three centres COP was a third option.

Blinding Single blind (assessors).

OUTCOMES

Recovery from all personality disorders at 3 years (not meeting SCID II criteria) When controlling for baseline severity, estimated recovery rates were significantly higher in people who received schema therapy (81.4%, 95% CI 67.4% to 90.2%), than people who received COP (60.0%, 95% CI 40.6% to 76.7%) or TAU (51.8%, 95% CI 38.3% to 65.0%). There was no significant difference in estimated recovery rates between COP and TAU. Effects did not differ according to specific-personality disorder or medication use, but recovery was higher in people who received schema therapy from therapists trained by exercises rather than by lectures.

Dropout rate When controlling for baseline severity, estimated dropout was lower for schema therapy (15.4%, 95% CI 7.6% to 28.5%) and COP (20.8%, 95% CI 10.3% to 37.6%) than for TAU (40.5%, 95% CI 29.4% to 52.7%).

Mood and anxiety disorders at 3 years (SCID I and II) Schema therapy significantly reduced risk of depressive disorder compared with TAU (estimated prevalence 13.5% with schema therapy, 12.2% with COP and 25.2% with TAU). There was no significant difference in estimated prevalence of anxiety disorders (27.5% with schema therapy, 35.1% with COP and 27.4% with TAU).

Other secondary outcomes Schema therapy significantly improved Global Assessment of Functioning Scale scores compared with TAU, and significantly improved Social and Occupational Functioning Assessment Scale scores compared with COP and TAU. No significant differences between groups were observed for self-assessments including the Symptom Checklist-90 and WHO Quality of Life Assessment.

Schema therapy is an effective treatment for avoidant, dependent and obsessive–compulsive personality disorders

Christopher J Hopwood and Katherine M Thomas

Evid Based Mental Health 2014 17: 90-91 originally published online July 9, 2014
doi: 10.1136/eb-2014-101858