

Short-Term Psychodynamic Psychotherapy for Personality Disorders:  
A Critical Review of Randomised Controlled Trials  
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Abstract

The research evidence for Short-Term Psychodynamic Psychotherapy (STPP) in the treatment of Personality Disorders (PD) was examined through consideration of studies utilising randomised controlled designs. An extensive literature search revealed eight published Randomised Controlled Trials (RCT) of moderate study quality. A critical review of this literature is offered to provide an evidence based guidance for clinicians and implications for treatments are discussed. Preliminary conclusions suggest STPP may be considered an efficacious empirically supported treatment option for a range of PDs, producing significant and medium to long-term improvements for a large percentage of patients. Further research is recommended to allow comparisons with alternative evidence based approaches.

Key Words: Psychotherapy, short-term, psychodynamic, randomised controlled trials, personality disorders

From our knowledge of the research literature, to date there have been no published reviews which specifically examine the efficacy of Short-Term Psychodynamic Psychotherapy (STPP) in the treatment of personality disorder (PD). This paper will therefore aim to critically examine the research literature around STPP treatments for PD to offer greater evidence-based guidance for working with this client group.

This paper will first aim to critically review the findings from studies utilising a randomised controlled trial (RCT) design to examine the effectiveness of STPP treatments for patients with PD. Where possible, findings for specific PD clusters will be distinguished and treatments effects will be compared between STPP and other psychotherapy models. Variations in structure and technique between STPP methods and the possible implications will be considered. In line with the research literature, possible treatment factors linked to outcome will be discussed and implications highlighted.

### Personality Disorders

With the rise in empirically validated treatment approaches, the view that people with a PD are untreatable is gradually being challenged. However, the long-standing, pervasive and inflexible patterns of behaviour seen within PDs make these disorders among the most challenging health presentations for mental health services to treat. In patients with PD, psychosocial impairment and the use of mental health resources is high (Perry, Lavori & Hoke, 1987; Dolan, Warren, Menzies & Norton, 1996; Bender, Dolan, Skodol, Sanislow, Dyck, McGlashan et al., 2001). Bateman & Tyrer (2004) have emphasised the complexity arising when assessing PDs based on the 'multifaceted' characteristic features of these disorders, in particular, the close connection between co-morbid disorders of personality (Tyrer, Gunderson & Lyons, 1997) and also clinical syndromes and PD (McGinn & Sanderson, 1995; Shea, Pilkonis, Beckham, Collins, Elkin, Sotsky et al., 1990).

Research around psychotherapeutic interventions for PD has been described as frequently difficult to interpret due to the shortage of adequately controlled trials (Bateman & Fonagy, 2000). An essential criterion for establishing the value of a treatment includes its efficacy being demonstrated in Randomised Controlled Trials (RCT) (Bateman & Tyrer, 2004). This makes it less likely that confounding variables can distort treatment effects. Psychodynamic therapy is however one of the few classes of treatment where the evidence for treatment effectiveness meets this criterion. The number of treatments which can be considered psychodynamic in nature is very broad therefore this review will aim to focus more specifically on brief psychodynamic psychotherapy as this has been applied to treating PD.

### Short-Term Psychodynamic Psychotherapy

Short-term psychodynamic psychotherapy (STPP) has been used within the literature as an overarching term for brief treatments which emanated from traditional psychodynamic and psychoanalytic theory. STPP was developed from the pioneering work of individuals such as Mann (1973), Malan (1976), Davanloo (1980) and Sifneos (1979). Common features distinguishing these include a limited number of sessions, the use of selection criteria to establish suitability for treatment, maintenance of a therapeutic focus, active therapist involvement, use of the transference (therapeutic) relationship. Furthermore, most STPP methods use the triangle of conflict (Ezriel, 1952) and the triangle of person (Menninger, 1963) in the therapeutic focus (Davanloo, 1980). Over the last 17 years the field has seen four meta-analyses which have sought to collate the research evidence for STPP treatments (Crits-Christoph, 1992; Anderson & Lambert, 1995; Leichenring, Rabung & Leibing, 2004; Abbass, Hancock, Henderson & Kisely, 2006). The consensus within this literature is that STPP offers a treatment option that is superior to minimal and waiting list controls and equal to other treatments across a broad range of common mental disorders. However, these reviews pertain to the treatment of psychiatric diagnoses as a whole and therefore do not address possible questions around the application of STPP as a treatment for specific mental disorders. In respect to PD, Two meta-analyses (Leichenring & Leibing, 2003; Perry, Bannon & Ianni, 1999) demonstrate that psychodynamically orientated psychotherapy reduces personality pathology, reduces symptoms and improves social functioning in patients presenting with a mixture

of PD clusters A, B, C and NOS (Not Otherwise Specified). Using broad inclusion criteria for selecting Psychodynamic treatments, these papers therefore fail to distinguish between different modalities of psychodynamically informed psychotherapies. The analyses and conclusions subsequently lack the sensitivity to detect differences between dynamic techniques, for example as seen in Psychoanalytic and time-limited methods. Studies included also consist of varied methodological rigour which limits the conclusions able to be reliably drawn. Since the Leichsenring & Leibling (2003) meta-analysis, new empirical data has been published (Abbass, Sheldon, Gyra & Kalpin, 2008; Emmelkamp, Benner, Kuipers, Feiertag, Koster & Van Apeldoorn, 2006; Svartberg, Stiles & Seltzer, 2004; Vinnars, Barber, Noren, Gallop & Wenryb, 2005) based on well controlled treatment studies of STPP with PD. Given these studies give a greater depth to the literature and having noted the gaps in past reviews it would therefore suggest that a more focused review of the literature around STPP treatments for PD is now warranted.

### Search Method & Criteria

Studies included in this review were RCTs which reported a short-term psychodynamic intervention for a sample with a confirmed psychiatric diagnosis of personality disorder. Initially, papers were found from a Cochrane review of STPP for mental disorders (Abbass et al., 2006). Next, the electronic databases MEDLINE, CINAHL, EMBASE, PsychINFO were searched to identify recently published papers. The search strategy included a range of synonyms, utilising both index terms and text words, for psychodynamic (e.g. dynamic, psychoanalytic, analytic), short-term (e.g. time-limited, brief) and personality disorder (personality disorder). Finally, reference lists from those studies identified and other relevant review papers were examined for additional papers of interest. In total, over 100 citations were identified, of which 16 were deemed potentially suitable for review. Independently, two reviewers assessed eligibility for selection using strict, predefined inclusion criteria. In line with the most recent Cochrane review around STPP treatments (Abbass et al., 2006), inclusion criteria for interventions examined in this review were psychotherapies in which i) at least one treatment group was psychodynamic in nature and lasted 40 weeks or less on average ii) the treatment technique was derived from the work of one or more developers of short-term psychodynamic psychotherapies such as Mann, Sifneos, Malan, Davanloo, Luborsky or was specifically developed and described for a brief psychodynamic approach iii) the treatment was given in an individual format iv) with standard length of sessions being 45-60 minutes. In addition, studies were only selected which met a definition of a RCT, that is, those that incorporate a comparison or control group for evaluating the effects and random assignment to treatment group. Finally, all participants were required to meet specific criteria for a psychiatric diagnosis of personality disorder. Disagreement was addressed through discussion and when consensus could not be reached a third reviewer was consulted. Eight studies were subsequently identified based on both judges' independent agreement. In the case of one study (Munroe-Blum and Marziali, 1995), its inclusion within the review centred on the treatment reported being considered a 'brief' treatment, adapted from an open ended traditional Psychoanalytic approach. It was therefore deemed to meet the selection criteria for inclusion, rather than being excluded due to the limited treatment description. Four additional studies that did not utilise a randomised allocation procedure but met all other inclusion criteria were identified. Given the small number of RCTs identified, these studies were deemed of potential interest and therefore will be considered in brief (Cornelissen & Verheul., 2002; Muran, Safran, Samstag & Winston., 2005; Diguier, Barber & Luborsky., 1993; Junkert-Tress, Schnierda, Hartkamp, Schmitz & Tress., 1991; Kool, Dekker, Duijsens, de Jonghe & Puite, 2003).

### Study Characteristics

For RCTs, the Cochrane Collaboration Depression Anxiety and Neurosis (CCDAN) (Moncreiff, Churchill, Drummond & McGuire, 2001) quality rating scale was used to rate the quality of studies. This validated scale contains 23 items examining a range of aspects of trial design and has a

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maximum value of 46. The CCDAN quality ratings for the eight RCT s averaged 29.6 (SD 5.9, Range 21-36) suggesting moderate study quality.

### STPP interventions for PD

In total, eight RCTs were identified reporting the brief dynamic treatments of patients with PD and in general these yielded positive results that persist upon follow-up averaging 19 months (SD 7.3). These results have been summarised through calculating mean effect sizes generated from pre and post outcome measurements for seven of the studies [see Table 1]. Across these studies outcome data has been collated by measurements of symptomatic, interpersonal and functional pathology. Mean effect sizes were all in the high range based on Cohen (1992).

*Table 1* offers an overview of the treatment effects seen across studies. The findings suggest that patients with PD show meaningful improvements in symptomatic (mean  $d=0.92$ ), interpersonal (mean  $d=0.86$ ) and functional pathology (mean  $d=1.47$ ) following STPP. Four studies also evaluated PD diagnostic information at follow-up; reductions in PD diagnoses ranged from 38% (Svartberg, Stiles & Seltzer, 2004) to 83.3% (Abbass, Sheldon, Gyra & Kalpin, 2008).

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*Table 1: Treatment Descriptors and Effect Sizes\* of Brief Psychodynamic Psychotherapy Randomised Controlled Trials of Patients with Personality Disorder\*\**

Study	STPP Intervention	N	PD Diagnosis (Cluster/ type)	CCDAN rating	Mean Total Sessions	Mean Length Follow-up(mth)	SCL-90, BSI or GSI ES	IIP ES	GAF ES	Drop outs (%)
Abbass et al., 2008.	ISTDP (Davanloo, 2000)	27	A, B and C	29	28	24	1.78	1.39	2.26	0
Hardy et al., 1995	Psychodynamic Interpersonal. (Hobson, 1985)	13	C	36	12	12	1.21	1.13		0
Hellerstein et al., 1998.	STDP (Davanloo, 1980)	25	A, B, C & NOS	24	29	6	0.27	0.31		40
Munroe-Blum et al., 1999	Dynamic psychotherapy (Kernberg, 1975)	26	Borderline	31	40	24	1.00			16
Svartberg et al., 2004.	STDP (McCullough-Vaillant, 1997)	25	C	30	40	24	0.95	1.04		0
Vinnars et al., 2005.	SE psychotherapy (Luborsky, 1984)	63	A, B and C	36	26	24	0.63	0.44	0.68	15
Winston et al., 1994.	STDP (Davanloo, 1980)	15	A, B and C	21	40	18	0.58			21
Mean (SD)										
				<b>29.6 (5.6)</b>	<b>30.7 (10.3)</b>	<b>18.9 (7.3)</b>	<b>0.92 (0.49)</b>	<b>0.86 (0.47)</b>	<b>1.47 (1.12)</b>	<b>11.5(14.0)</b> □

\*Effect size was computed by dividing the pre versus post score difference by the pooled standard deviation. Effects sizes of 0.2 are small, 0.5 are medium and 0.8 are large. Data from longest follow-ups were used to calculate the mean treatment effects.

\*\* Note: an 8<sup>th</sup> study, Emmelkamp et al., 2006, did not use any of the common measures listed.

SCL: Symptom Checklist; BSI: Brief Symptom Inventory; GSI: Global Symptom Index; IIP: Inventory of Interpersonal Problems; GAF: Global Assessment of Functioning; ES: Effect Size

□ When calculating the mean number of dropouts, the total number of treatment dropouts in the Munroe-Blum & Marziali (1995) study was used due to insufficient data from the STPP group. The figure of zero dropouts reported by Emmelkamp et al., (2006) was also included within the analysis.

Treatment Outcome: Between & within PD clusters:

It can be seen from *Table 1* that Cluster C PDs are the most prevalent diagnoses researched within this literature. This diagnostic group represents the anxious fearful cluster, including obsessive-compulsive, avoidant and dependent categories. Individuals with these presentations, rather than cluster A or B PDs, have typically been seen as less fragile and therefore more suitable candidates for brief dynamic therapies. This may partially explain the disproportionate amount of research carried out with Cluster C PD. Criteria for assessing suitability for STPP treatments has evolved over time and may be seen to differ between different STPP models. Earlier methods (Davanloo, 1980; Sifneos, 1979; Mann, 1973) put greater emphasis on anxiety provoking techniques. Cluster A and B personality diagnoses such as narcissistic and paranoid types were seen as less suitable for these methods and subsequently excluded from clinical trials using these techniques (Hellerstein, Rosenthal, Pinsker, Samstag, Muran, & Winston, 1998; Winston, Pollack, Laikin, Samstag, McCullough & Muran, 1994). STPP approaches have been developed to treat either specific categories of PD, as described by Munroe-Blum and Marziali (1995), or through revisions to technique (Davanloo, 2000) as implemented by Abbass et al. (2008).

Two studies examined Cluster C exclusively (Hardy, Barkam, Shapiro, Stiles, Ressler & Reynolds (1995); Svartberg et al., 2004). In this first study, patients were randomly assigned to receive 8 or 16 sessions of either cognitive behavioural therapy (CBT) or psychodynamic interpersonal (PI) psychotherapy. The latter treatment type was described as a relationship orientated treatment based on Hobson's Conversational model (Hobson, 1985). In the second study, patients received a 40 session Anxiety Regulating STPP treatment (McCullough Vaillant, 1997). At long-term follow-up, patients in both studies (Svartberg et al., 2004; Hardy et al., 1995) receiving STPP showed medium to large within group treatment effects for symptom distress ( $d=0.95$ ,  $d=1.21$ ) and interpersonal problems ( $d= 1.04$ ,  $d=1.13$ ) respectively. Svartberg et al. (2004) also reported a 16% reduction in personality pathology between baseline and termination which reduced a further 22% at follow-up.

A further study treated a sample of patients with a primary diagnosis of Avoidant PD (Emmelkamp et al, 2006). Twenty-three patients received on average 18.8 sessions of BDT. This treatment was not manualised rather tailored to the client's presentation. It was described as utilising both traditional dynamic techniques, particularly interpretation (Malan, 1976, 1979) and supportive interventions, based on the recommendations of Luborsky (1984). Based on Cohen (1992) medium to large treatment effects ( $d = .50$  to  $.80$ ) were seen in the STPP condition on all the primary outcome measures constituting self-report measures tapping avoidant traits, anxiety symptoms, and social phobia. At 6 month follow up 16 of 25 patients who received STPP no-longer fulfilled criteria for Avoidant PD. The authors highlight that this reflects a 64% reduction in the disorder which can be considered significant compared to the 33% reduction described by Shea, Shrout and Gunderson (2002). The validity of these findings is however somewhat limited by the lack of an extended follow-up assessment demonstrating treatment effects were maintained and long lasting.

A fourth study (Muran et al., 2005), which used a non-random comparative design, selected patients who met Axis II criteria for either Cluster C PD or PD NOS. Two-thirds of the sample had been diagnosed with PD NOS. Similar to the previous studies discussed Avoidant category was the most common Cluster C diagnosis. The NOS PD category, alongside Cluster C types, is seen as less severe than Cluster A or B diagnoses therefore the sample studied can be considered comparable to that treated by Emmelkamp et al. (2006), Hardy et al. (1995) and Svartberg et al. (2004). Based on the reported outcome data at 6-month follow-up, treatment effects in the STPP group were in the small-medium range for interpersonal problems ( $d = .031$ ) and a negative effect was seen for symptom distress ( $d = -.017$ ). However, further analysis calculating clinically significant change on these outcome measures revealed that 27% and 31% of patients who received STPP, moved from dysfunctional to the functional range by termination on the Symptom Checklist (SCL-90- Derogatis, 1983) and Inventory of Interpersonal Problems (IIP- Horowitz, Rosenberg, Baer, Ureno & Villaseñor, 1988) respectively. At follow-up, the degree of clinically significant symptomatic change within the sample had been maintained but fewer patients remained in the functional range on the measure of

interpersonal difficulties. Although this STPP treatment for solely PD Cluster C would not appear as efficacious as that previously reported, significant symptomatic, interpersonal and functional improvements were still found. It should be noted that whilst the treatment model in question was manualised, the nature of its development and origin were unclear.

One RCT was identified pertaining exclusively to the treatment of BPD (Munroe-Blum & Marziali, 1995). This study reported data on twenty-six patients treated with STPP. At 12 month follow-up significant differences on measures of social dysfunction (Objective Behaviour Index; Munroe-Blum & Marziali, 1986), social adjustment (SAS; Weissman & Bothwell, 1976), global symptoms (HSCL-90; Derogatis, Lipman, & Covi, 1973) and depression (BDI; Beck, Ward, Mendelsohn, Mock, & Erbaugh, 1961) were seen compared to pre-treatment. These improvements were maintained at 24 month follow-up and persisted on all measures. In a sample where a large percentage of the patients treated were deemed to be in the severe range of impairment these results suggest that STPP can offer an efficacious treatment option for PDs once considered too fragile for these techniques. This finding is further supported by the most recent RCT identified (Abbass et al., 2008) which reported large group treatment effects (*see Table 1*) on symptomatic ( $d = 1.78$ ), interpersonal ( $d = 1.39$ ) and functional measures ( $d = 2.26$ ) which were maintained at long-term follow-up in a sample where 44% of patients met criteria for BPD. This research would therefore suggest that it would be premature to continue to exclude patients with BPD from receiving STPP prior to a thorough assessment around treatment suitability or a trial of therapy (Abbass, Joffres & Ogronczuk, 2008).

Whilst the research evidence has been conducted mostly with Cluster C PD, with the exception of the BPD cases described, a small number of patients with Cluster A and B PD diagnoses were treated within the Abbass et al. (2008) and Winston et al. (1994) studies. As a whole, both samples showed therapeutic gain following STPP. Vinnars et al. (2005) treated the entire range of PD diagnoses and reported patients evidencing increased global level of functioning, and a reduction in PD diagnoses, PD severity, and psychiatric symptoms. Clinical outcomes at one year follow-up revealed statistical change in functional impairment in respect to both treatment group and personality cluster. Patients receiving STPP diagnosed with PD NOS improved the most, while those with Cluster A diagnoses improved the least. These findings suggest that PD diagnostic groups may be considered on a spectrum of severity which could inform likely treatment efficacy.

In summary, eight RCTs have been conducted treating patients largely with Cluster C category PDs. STPP was found to be an efficacious treatment with this population evidencing medium to long-term treatment effects. Two studies suggested that STPP can be similarly effective with BPD (Abbass et al., 2008; Munroe-Blum & Marziali, 1995). A number of studies examining a mixture of Clusters A, B and C PDs reported positive outcomes, however, the results from Vinnars et al. (2005) suggest that within these samples differential treatment effect may exist between clusters. None of the trials treated patients with schizoid or schizotypal PD.

### Comparing Different models of STPP

It may be understood that under the broad category of STPP exists a range of brief models which can be distinguished by the series of technical interventions employed. It could be considered both a strength and limitation of this review that the literature examined covers a range of different STPP therapy models. Whilst the conclusions may on one hand therefore be generalisable to the spectrum of STPP treatments, they also lack specificity to examine differential treatment effects more closely. The same may be said of CBT meta-analyses whereby CBT vs Behaviour Therapy (BT) vs mixed variants are included under the same rubric (Kroenke & Swindle, 2000).

Two RCTs have been conducted which examine the efficacy of STPP manualised treatments based on the early iteration of Davanloo (1980), (Hellerstein et al., 1998; Winston et al., 1994). In this model, the therapist adopts an active stance to addressing patients' conflicts and eliciting patient affect, and relative to other STPP employs greater use of pressure and challenge when faced with characterological resistance. The treatment course in these studies was comparable in respect to mean length of treatment. The findings revealed a statistically significant reduction in patients' self-

reported symptom distress at the end of treatment and improved social adjustment. Winston et al.'s (1994) findings indicated that STDP was an active treatment with patients experiencing significantly more improvement than a waiting list control group. The small sample sizes made up of relatively high functioning individuals do however limit the power and generalisability of the findings. Nevertheless, Davanloo's early method (before 1980) was found to be comparable to both cognitive and psychodynamic treatment approaches and superior to a waiting list control (Hellerstein et al., 1998; Winston et al., 1994).

Abbass et al. (2008) evaluated the efficacy of the refined version of Davanloo's technique, (Davanloo, 2000), Intensive Short-Term Dynamic Psychotherapy (ISTDP), compared to a minimal contact control group. This method emphasises the activation of the "unconscious therapeutic alliance" to enable the somatic experience of unconscious feelings related to attachment trauma as the curative factor in PD. Control patients later received ISTDP treatment and analyses were carried out on the whole sample. The ISTDP group (mean number of sessions 27.7) showed a significantly greater level of improvement than the control comparison on all of the primary outcome measures. When the control group was provided ISTDP, similar gains to the initial treatment group were observed. Based on reduced medication usage and disability payments, the authors also highlighted the cost-effectiveness of this treatment (Abbass, 2003). A limitation of the study is the relatively small final sample (N=27). Nevertheless, Abbass et al. (2008) demonstrated a highly efficacious STPP treatment most clearly evidenced by an 83.3% reduction in PD diagnoses at long-term follow-up. Davanloo's current ISTDP model (Davanloo, 2000) showed even larger treatment effects than his earlier STDP model (Hellerstein et al., 1998; Winston et al., 1994) and was the only model to bring IIP ratings into the normal range.

Luborsky's (1984) supportive-expressive therapy (SE) aims at helping patients develop a greater understanding of conflictual interpersonal patterns in the context of a supportive relationship. Piper (1996) distinguished SE therapy from approaches with a greater affect focus (e.g. Davanloo, 1980) using a continua which highlighted technical interventions focusing less on the transference and applying pressure to exploring painful emotions about past figures, and a greater degree of therapist praise, guidance and self-disclosure. Vinnars et al. (2005) delivered SE to a sample of 61 patients with PD. Given the significant number of patients treated, the moderate effects on psychiatric symptoms ( $d = .63$ ) and adaptive functioning ( $d = .68$ ) at 2 year follow-up are clinically important. No further RCTs were identified which corroborate the efficacy of this manualised STPP for PD, however, it is notable that a number of the STPP treatments cited Luborsky's (1984) methods and a body of naturalistic studies support these findings with mixed diagnostic samples (e.g. Barber, Morse, Krakauer, Chiltams & Crits-Christoph, 1997) and PD (Diguier, Barber & Luborsky, 1993). Svartberg et al. (2004) treated patients using an Anxiety Regulating dynamic model (McCullough-Vaillant, 1997). This shares many features of earlier brief dynamic models (Davanloo, 1980; Mann, 1973; Sifneos, 1979) however primary distinctions include therapists clarifying rather than challenging defences and anxiety being regulated as opposed to provoked using supportive techniques thus drawing some comparison with Luborsky's (1984) treatment model. In a study of Cluster C PDs, this brief dynamic treatment brought about a significant decrease in symptoms at termination which was maintained at 2 year follow-up (Svartberg et al., 2004). Table 1 shows that large treatment effects, based on Cohen (1992), were found for both symptom distress ( $d = .95$ ) and interpersonal problems ( $d = 1.04$ ).

In addition, a ninth RCT identified showed that the combined treatment of STPP and pharmacotherapy for PD and comorbid depression proved statistically more effective in bringing symptom relief on a range of measures in comparison to pharmacotherapy alone (Kool, Dekker, Duijsens, de Jonghe & Puite, 2003). These findings are noteworthy despite the studies subsequent exclusion based on the STPP condition existing as a combined treatment with antidepressants. Further studies identified using non-randomised, controlled designs (Muran et al., 2005; Hoglend, 1993; Junkert-Tress, Schnierda, Hartkamp, Schmitz, & Tress, 2001) reported improved outcome in



patients with PD following manualised short-term treatments based on modifications to the approaches described by Strupp & Binder, Luborsky, Sifneos and Malan.

In summary, it would appear there is sufficient evidence to suggest that early models of STPP based on Davanloo (1980) offers an efficacious treatment for PD with moderate treatment effects based on Winston et al. (1994) and Hellerstein et al. (1998). Further controlled studies are required to support the findings of Abbass et al. (2008) and Svartberg et al. (2004) indicating that greater treatment efficacy can be achieved through implementing revised STPP techniques.

### Dropouts within STPP Treatments

Empirical evidence comparing the number of patients who fail to complete treatment (dropouts) between different treatments is rarely written about. However, characteristically, patients with PD are seen as difficult to engage. It has been suggested that approaches which emphasise a focus on emotional experiencing through “pressure” and “challenge” are less comfortable for patients (Vinnars et al., 2005). It might be hypothesised that as a result these therapies are more likely to see higher rates of dropouts linked to possible misalliance or the anxiety provoking nature of therapy. This however does not appear to be the case within this literature.

The mean dropout rate<sup>1</sup> within the eight RCTs was 11.5% (SD = 14.0). Wierzbicki and Pekarik’s (1993) review calculated a mean psychotherapy dropout rate of 46.86% (SD = 22.25). It would therefore seem the number of patients with PD not completing STPP treatments was less than might be expected. The low dropout rate within this literature may be accounted for by the stipulated requirements for participation in a clinical trial producing a self-selecting bias in patient sampling towards those more motivated to engage in treatment. However, it is also likely that characteristic features of STPPs may contribute to lower percentages of patient dropouts in some cases. In particular, entering treatment with a time-pressure may promote therapeutic engagement and motivation to make the most of therapy. STPPs also typically aim to establish the therapeutic focus early in treatment and address defensive barriers to the achievement of these shared objectives. In this way, longstanding, maladaptive interpersonal patterns seen in PD can be prevented from strangling the therapeutic relationship and therefore potentially minimising the likelihood of dropouts.

### Comparisons Between STPP and Other Treatments

Three separate clinical trials (Winston et al., 1994; Hellerstein et al., 1998; Muran et al., 2005) examined treatment efficacy in comparable STPP treatments against three different time-limited, manual based psychodynamic psychotherapy treatments (Brief Adaptional Psychotherapy (BAP)-Flegenheimer, 1989; Brief Supportive Psychotherapy (BSP) and Brief Relational Therapy (BRT)-Muran & Safran, 2002) respectively. Common similarities between these models include the use of techniques such as clarification and making links between current and past interpersonal patterns in relationships. In summary, all three studies found that the treatment effects in the STPP conditions were comparable to those seen in the other contrasting models of short-term therapy.

Four of the clinical trials identified in this review offer interesting comparisons between STPP and CBT or CT treatments for PD (Emmelkamp et al., 2006; Hardy et al., 1995; Muran et al., 2005; Svartberg et al., 2004). Emmelkamp et al. (2006) found that the STPP treatment was not superior to CBT on any of the outcome measures taken post-treatment or at follow-up. In contrast, when within group differences were examined, Svartberg et al. (2004) found statistically significant symptom change between termination and long-term follow-up in the STPP group but not in the CT group; the rate of change was almost twice that seen in the CT group. Similarly, post-hoc analyses on recovery rates at 2-year follow-up on the Millon Clinical Multiaxial Inventory (Millon, 1984)) revealed

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<sup>1</sup> The total number of treatment dropouts in the Munroe-Blum & Marziali (1995) study was used when calculating the overall mean number of dropouts for the STPP treatments due to insufficient data from the STPP group.

statistically significant for patients receiving STPP but not CT. However, between group comparisons in Svartberg et al. (2004) Hardy et al. (1995) and Muran et al. (2005) reported no statistically significant differences in change on any measure. In summary, these comparisons support the findings of meta-analytic studies (Leichsenring & Leibling, 2003; Perry, Bannon & Ianni, 1999) suggesting that both CBT/CT and STPP can be efficacious treatments for PD.

Healthcare providers are continually looking for alternative ways to further meet the economic pressures around providing treatments to common mental health presentations such as PD therefore group treatments and community based interventions may be seen to offer a more accessible and therefore viable treatment option than the controlled setting of university-based manualised treatment programs. Vinnars et al. (2005) reported an RCT comparing manualised SE psychotherapy (Luborsky, 1984) or a non-manualised community delivered open-ended psychodynamic treatment. It was unfortunately unclear what treatment patients in the community were receiving. Overall, the findings from this trial suggested that both an STPP treatment and community delivered psychodynamic treatment are efficacious interventions for PD and associated psychiatric symptoms. However, significantly more patients in the community treatment group had additional treatment after 1 year follow-up. A limitation of this study is the unexplained treatment effects of approximately half of the sample being given psychotropic medication during the treatment phase and a significant number of patients receiving additional treatment between termination and follow-up. Given the possibility treatments were more similar than different, these findings raise the question around the importance of therapists strictly adhering to therapy manuals. Munroe-Blum & Marziali (1995) compared a short-term group treatment against an individual dynamic psychotherapy treatment (Kernberg, 1975). Major outcome variables of interest were social dysfunction, social performance, and symptom status. Significant differences were found on all of these indicators at 12 month follow-up compared to pre-treatment, however, between group treatment effects were not seen. These improvements were maintained at 24 months follow-up and persisted on all measures. It is of clinical importance that the authors note that therapists participating in the group intervention reported less anxiety and greater satisfaction than did the therapists conducting STPP. The short-term group treatment also offered what was an equally efficacious treatment to more patients over a shorter period of time compared to the STPP treatment. Using a naturalistic study design, Cornelissen & Verheul (2002) have shown that Davanloo's ISTDP model can also be effectively translated to a combined individual and group treatment with treatment effects maintained at 10-year follow-up (Cornelissen, Smeets, Williemsens, Busschback & Verheul). Based on the tangible benefits of a group treatment and at least equal treatment effects compared to individual STPP having been shown (Munroe-Blum & Marziali, 1995), further controlled research around the application of group STPP is warranted.

## CONCLUSIONS

A literature search revealed eight published randomised controlled trials reporting the efficacy of STPP treatments for PD. Overall this literature suggests that STPP offers an efficacious treatment option for PD, superior to waiting list controls, and comparable to psychodynamic and cognitive behavioural approaches. Further research is warranted to clarify these latter two findings. The literature offered research evidence for treatments of PD Clusters A, B, C and NOS, however, a number of studies pertained exclusively to Cluster C presentations. STPP appears to be effective for a range of PDs, producing robust and persistent symptom and interpersonal problem improvement. However, the PD samples treated were in some cases made up of relatively high functioning individuals as studies typically applied exclusion criteria for more complex presentations. As such, the generalisability of these findings to a broader PD population is somewhat limited.

Overall, there was not significant evidence that one approach was more effective than another. Although two studies found that the efficacy of CBT and STPP treatment for PD could be differentiated (Emmelkamp et al., 2006; Svartberg et al., 2004), contradictory findings (Hardy et al., 1995; Muran et al., 2005) highlight the need for further research to allow reliable conclusions to be

made around preferential treatment options. These findings are consistent with previous research suggesting it is not possible to clearly distinguish effects between active manualised psychotherapies (Lambert, 2004).

Given this summary of the evidence, based on Chambless and Hollon's (1998) criteria for Empirically Supported Therapies, STPP can be considered at least 'possibly efficacious' in the treatment of PD. The designation of an 'efficacious' treatment is problematic to achieve for psychotherapy treatments due to the requirement of sufficient investigator independence in at least two studies. Based on the use of therapists who were independent to the research team, but trained by knowledgeable experts in the field, in studies by Svartberg et al. (2004) and Emmelkamp et al. (2006), sufficient investigator independence appears to have been demonstrated to satisfy this criteria. Further replication of these findings with similarly well controlled studies can only clarify the implication that STPP be considered an Empirically Supported Treatment for PD.

Strengths of the literature reviewed include a focus on randomised controlled trial designs. Reviewed studies also employed extended follow-up periods, on average extending to over 18 months, demonstrating effects were maintained and long lasting. The use of manualised approaches, adherence ratings and expert supervision ensured treatment fidelity was maintained within the STPP treatments. This may be seen as consistent with Anderson and Lambert's (1995) meta-analytic finding that studies employing treatments manuals or trained STDP therapists had larger effect sizes. This would suggest that adherence to the interventions described within STPP manuals is likely to be an important feature around treatment efficacy.

Limitations of the literature reviewed include the differential use of diagnostic methods for identifying PDs between studies e.g. patient self-report, interview measures, and different DSM definitions. Secondly, although strict selection criteria ensured STPP treatments examined retained core similarities, there were also differences between the techniques used in these therapies.

### Research Implications

It is recognised that Axis I and Axis II comorbidity complicate both diagnosis and treatment of PD (Pilkonis, Neighbors & Corbitt, 1999). Greater conceptual clarity is necessary around the measurement of PD and comorbid disorders. At present studies are typically made up of widely heterogeneous samples making it difficult to draw out findings from the literature. These recommendations may be aided by the use of a broader range of outcome measures e.g. tapping impairment and social functioning, less reliance on self-report measures instead using shared outcome measures and the perspectives of other sources.

To advance the current literature it would be important to replicate the findings of one-off studies which showed large treatment effects for revised STPP treatments (Abbass et al., 2008; Svartberg et al., 2004). Furthermore, methodological limitations of the existing literature that should be addressed in future research includes greater utilisation of non-active control groups and larger sample sizes.

Whilst the standard outcome measures typically used within these studies allowed a degree of comparison between effects, in turn they limit between-treatment differentiability. In attempting to truly understand processes that occur within therapy, the relationship and interactions between therapist behaviour and patient response must be better understood. Further research may therefore require the use of theory-specific measures to enable a greater understanding about specific treatments alongside a consideration around common change mechanisms within psychotherapy.

Future research is also necessary with larger treatment groups, distinguishing between emotion-focused and insight based treatments, for the severe personality clusters A and B. Study quality would be improved with specification of severity alongside diagnosis and the utilisation of a non-active or waiting list controls group.

### Clinical Implications

This review is of interest to clinicians working with this particularly difficult to treat and high service-using client population (Bender et al., 2001; Zanarini et al., 2003). Since STPP's are brief, they appear to be not only a valid treatment option but a cost-effective one.

Of clinical note therapists should consider a tailored treatment-assessment or trial therapy to determine a client's suitability for STPP (Abbass, Joffres & Ogrodniczuk, 2008). Davanloo's method for example, employs a series of coordinated technical interventions and monitors response to determine anxiety tolerance and defensive operations in order to map treatment. Other methods rely on trial interpretations, other forms of in-session feedback or selection criteria of variable stringency. It is our view that PD patients should be given the benefit of the doubt and offered a trial of STPP before referring them for longer or more costly therapies or pharmacotherapy. In two-thirds of the STPP studies reviewed, therapist experience and case assignment varied widely however, treatment adherence and fidelity checks against a manualised protocol were used across studies. Whilst these findings do not therefore indicate a therapist need be an expert to offer an efficacious treatment, familiarity with the techniques through training and expert supervision may be necessary to ensure adherence. This echoes Deiner & Hilsenroth's (2007) recommendation highlighting the importance of close supervision of 'actual techniques' to maximise patient improvement in psychodynamic psychotherapy.

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