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The effectiveness of evidence-based treatments for personality disorders when comparing treatment-as-usual and bona fide treatments ☆

Stephanie L. Budge [a,*], Jonathan T. Moore [a], A.C. Del Re [b], Bruce E. Wampold [c,d], Timothy P. Baardseth [e], Jacob B. Nienhuis [a]

[a] University of Louisville, United States
[b] Stanford University, United States
[c] University of Wisconsin-Madison, United States
[d] Research Institute, Modum Bad Psychiatric Center, Norway
[e] Hines Veterans Affairs Hospital, United States

HIGHLIGHTS

- Significant effect for EBTs when compared to TAU for personality disorders
- Significant heterogeneity among studies comparing EBTs to TAU
- Diagnosis of BPD attributed to the differences in the main effect.
- Significant effect size for bona fide treatments for personality disorders
- Two studies primarily contributed to the omnibus effect for bona fide treatments.

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ABSTRACT

Objective: The purpose of Study 1 was to examine the relative efficacy of evidence-based treatments (EBTs) when compared to treatment-as-usual (TAU) for adults diagnosed with a personality disorder (PD). The purpose of Study 2 was to investigate the strength of the differences between bona fide psychotherapeutic treatments for PDs.

Method: Two separate computerized searches were conducted of: (a) studies that directly compared an EBT with a TAU for treatment of PDs, or (b) studies that compared at least two bona fide treatments for PDs. Meta-analytic methods were used to estimate the effectiveness of the treatments when compared to one another and to model how various confounding variables impacted the results of this comparative research.

Results: A total of 30 studies (Study 1; $N = 1662$) were included in the meta-analysis comparing EBTs to TAU. A total of 12 studies (Study 2; $N = 723$) were included in the meta-analysis comparing bona fide treatments. Study 1 found that EBTs were superior to TAU, although the TAU conditions were not comparable in many respects (e.g., not psychotherapy, lacking supervision, lacking training, etc.) to the EBT and there was significant heterogeneity in the effects. Study 2 found that some bona fide treatments were superior to others.

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* Corresponding author at: Educational and Counseling Psychology, Counseling, and College Student Personnel, University of Louisville, 327 Education Building, Louisville, KY 40292, United States. Tel.: +1 502 852 0627.
E-mail address: stephanie.budge@louisville.edu (S.L. Budge).

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1. Introduction

Personality disorders (PDs) have received substantial attention in psychological treatment literature due to the severity of symptoms, especially when compared to other classes of diagnoses (Crits-Cristoph & Barber, 2002; Soeteman et al., 2010, 2011). PDs tend be more stable and enduring than other forms of mental illness detailed in the *Diagnostic and Statistical Manual of Mental Disorders* and are typified by the pervasive, serious, and rigid self-destructive patterns in affect, cognition, interpersonal relations, and impulse control that impact psychological well-being (APA, 2000). PDs are associated with higher rates of self-injurious behaviors, including suicide (McMain, 2007), as well as functional impairment and extensive treatment usage resulting in higher healthcare costs (Hadjipavlou & Ogrodniczuk, 2010; Soeteman et al., 2011). Diagnostically, PDs are commonly occurring types of psychological disturbance, with prevalence rates ranging between 6 and 13% (Lenzenweger, 2008; Samuels, 2011). Additionally, PDs are highly comorbid with Axis I disorders, particularly anxiety and mood disorders (Ruegg & Frances, 1995). Often the focus of treatment is on Axis I disorders, however the presence of a PD typically attenuates the effectiveness of treatments for the Axis I disorders (Crits-Cristoph & Barber, 2002).

Although historically it was believed that psychotherapy was not effective for persons with PD (e.g., Bateman & Fonagy, 2000; Hadjipavlou & Ogrodniczuk, 2010), there is increasing evidence that psychotherapy is the treatment of choice for treating PDs (Bateman & Fonagy, 2000; Binks et al., 2006a; Gabbard, 2000; Leischsenring & Leibing, 2003; Ogrodniczuk & Piper, 2001; Perry, Banon, & Ianni, 1999; Perry & Bond, 2000; Sanislow & McGlashan, 1998; Shea, 1993; Verheul & Herbrink, 2007). Psychotherapy has shown more promising results than alternative treatments, such as pharmacological interventions (Binks et al., 2006b; Duggan, Huband, Smailagic, Ferriter, & Adams, 2008; Gibbon et al., 2011; Paris, 2011; Stoffers et al., 2010). General aggregate effect sizes on pretreatment to posttreatment outcome measures associated with PDs range from 1.1 to 1.3 (Perry et al., 1999) and .87 to 1.79 specifically for cognitive behavior and psychodynamic therapies, respectively (Leischsenring & Leibing, 2003). Benchmarked effect sizes for depression range from .88 to 1.15 (Minami et al., 2008); when considering that effect sizes above .8 are considered large (Cohen, 1977), and that aggregated effect sizes for PD treatments surpass benchmarking studies for depression, it appears that psychotherapeutic treatments for PDs are effective. While important contributions to the field, current meta-analyses related to PDs are limited by including uncontrolled observational studies. Additionally, meta-analyses of PDs disproportionately focus on borderline personality disorder (BPD); the remaining 9 (DSM-IV-TR) PDs are studied less frequently (Hadjipavlou & Ogrodniczuk, 2010).

Research of psychotherapeutic treatments has evolved over time to delineate: (a) if treatments are effective, (b) which treatments are more effective than others, and (c) the specific ingredients of the treatments that are particularly effective. The evidence-based treatment (EBT) movement—which is now considered the paragon for ascertaining the viability of treatments (Westen, Novotny, & Thompson-Brenner, 2004)—outlines specific criteria psychotherapy trials should meet in order to establish treatment efficacy. In order for a treatment to be considered well established, it must have demonstrated that its benefits exceed those of some alternative treatment or placebo condition (Chambless & Hollon, 1998). Further, these standards also apply to effectiveness studies (e.g., studies that determine the transferability of efficacious treatments to naturalistic settings). More often than not, treatment-as-usual (TAU) is considered the alternative comparison-group-of-choice when determining if an EBT will be effective in the community.

Operationally, TAU is meant to be a psychotherapeutic treatment that is being offered in a naturalistic setting, and most likely includes integrative, non-manualized treatments provided by masters and doctoral level clinicians. For anxiety and depression, evidence based treatments (EBTs) have been found to be superior to TAU only when TAU did not include psychotherapy services (Wampold et al., 2011). One of the primary conclusions from the Wampold et al. study was that TAUs are poorly implemented as a comparison group for depression and anxiety treatments; more often than not TAU was a no-treatment group, but even when it was an actual treatment, TAU was implemented without therapist training, supervision, or support comparable to what was provided in the EBT condition.

Thus far, a multitude of studies examining PDs have utilized TAU as a comparison group—it appears that the same problems detected by Wampold et al. (2011) may be true for PD studies. Bender (2011) indicates, "Most clinicians are not adequately trained to treat BPD. Thus, in many cases, using treatment-as-usual as the comparison group is like a race between someone who carbo-loaded the night before and a person who hasn't eaten in 3 days" (p. 323–324). While psychotherapeutic treatments are considered the treatment of choice for PDs due to their purported effectiveness, it remains unknown whether the development and testing of particular EBTs for PDs has improved the quality of service. That is, does delivery of an EBT result in superior outcomes relative to other treatments or to TAU given by therapists who treat PD? To date, no comprehensive analysis of PD studies using TAU has been conducted to investigate whether TAUs used in the primary studies are adequate or to determine the effectiveness of EBTs relative to TAU.

In response to poorly implemented TAU comparison groups, critics have called for more robust control groups (Wampold et al., 2011). As it is difficult to determine how effective treatments may be when using TAU as a comparison, an alternative method is to compare two