Common and specific factors in psychological treatment of personality pathology

ARTICLE

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SUMMARY

Cognitive–behavioural therapy (CBT) has been widely used for a broad range of mental health problems for several decades and has been researched extensively. Its techniques are relatively easy to learn and follow in treatment protocols. Many new CBT-based psychotherapies have been developed that go further than traditional CBT, some specifically addressing personality disorders. These so-called third-wave approaches target emotional responses to situations by using strategies such as mindfulness exercises and acceptance of unpleasant thoughts and feelings (observing thoughts as 'from afar'). In this article, we discuss the historical context of these therapies, dissect common and specific factors in some treatment modalities often used to treat personality disorders, and suggest potential future directions for research and treatment.

LEARNING OBJECTIVES

After reading this article you will be able to:

- understand the history of cognitive–behavioural therapy (CBT) and its adaptations as a treatment for personality disorders
- understand the specific factors that distinguish several adaptations of CBT for personality disorder
- understand which common factors influence outcome across adaptations of CBT for personality disorder.

KEYWORDS

Personality disorder; psychological treatment; common factors; therapy; mental health.

The development of personality disorders is influenced by an interplay of psychological and social factors, grounded in various theoretical frameworks. The interplay of these factors underscores the complexity of understanding and treating personality disorders. For example, therapy involves navigating several challenges, such as establishing and maintaining a strong therapeutic alliance, as individuals with personality disorders often exhibit mistrust, fear of abandonment or intense emotional reactions that can disrupt the therapeutic relationship. Psychological treatment for personality disorders has evolved significantly with the introduction of 'third-wave' therapies. These approaches differ from traditional cognitive–behavioural therapies by emphasising the contextual relationship between thoughts, emotions and behaviours. By addressing the underlying processes, third-wave therapies offer a comprehensive approach to managing the pervasive and enduring symptoms of personality disorders.

Historical background

The origin of all third-wave cognitive therapies is cognitive–behavioural therapy (CBT). We will not give an exhaustive review of the history of CBT here, as excellent descriptions already exist (e.g. Thoma 2015). Instead, we merely summarise the main developments.

Two movements formed the foundation of CBT: behavioural therapy and cognitive therapy. Behavioural therapy stemmed from the behaviourist movement, which aimed to include psychology among the natural sciences and to understand and manipulate behaviour through experiments. The three basic concepts of behaviourism are classical conditioning, operant conditioning and learning through modelling. These combined approaches formed the basis of the wider application of behavioural therapy in the 1960s. In response to the behaviourist movement some thought that cognitions and emotions were largely overlooked, which led to the 'cognitive revolution', which later led to the development of cognitive therapy. The founding father of cognitive therapy, Aaron Beck, developed therapeutic techniques aimed at identifying cognitive distortions and restructuring these in order to curb the process of negative automatic thoughts.

Although the work of Beck initially focused on depression, CBT developed into a mainstream treatment modality for many different mental disorders. In the 1990s psychologists and scholars started integrating mindfulness and the principles of non-judgemental acceptance into traditional CBT. These

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new therapies focus less on challenging thoughts and more on other pathways to change, such as emotions, emotion regulation and mentalisation.

Specific factors in commonly used therapies

A range of therapies are offered to patients with personality disorders and here we briefly explain some of the most frequently used ones.

Cognitive–behavioural therapy

The framework of CBT rests on consists of four premises. The first is that people have cognitive representations ('schemas') of their environment and they tend to respond to those representations rather than to the environment itself. Second, it is hypothesised that these representations are functionally linked to the process of learning. Third, most learning is 'cognitively mediated', which is the idea that cognitive processes occur after the presentation of a stimulus. And finally, cognition, emotion and behaviour all influence each other. Accordingly, personality disorders are caused by cognitive manifestations of maladaptive schemas of the self and others (Turner 1992).

CBT has three phases. The assessment phase is aimed at examining the symptoms and problems the patient presents with. Next is the intervention phase, where change is the goal, through the use of cognitive and behavioural strategies. The final phase is the termination phase, where therapist and patient work towards ending treatment. Within the CBT framework, a number of strategies are available to change maladaptive schemas, such as their replacement with functional ones, changing certain aspects of a maladaptive schema, or reinterpretation. The CBT therapist is equipped with a number of therapeutic techniques to achieve this goal, such as cognitive restructuring or reframing, relaxation techniques and guided discovery.

CBT is considered effective for a variety of mental health problems, including depression and anxiety disorders. However, when applied to personality disorders results are mixed, with some studies showing larger effects for CBT than for other forms of therapy but other studies showing the opposite. Most evidence of effectiveness of CBT in personality disorder relates to individuals with borderline and avoidant traits, and research on patients with other personality traits is limited (Matusiewicz 2010). A meta-analysis by Gibbon et al (2020) compared the efficacy of 11 different psychological therapies, including CBT, for antisocial personality disorder (ASPD). Results suggested that compared with control conditions, CBT plus 'standard maintenance' was more effective in reducing early treatment drop-out and cocaine use among out-patients with ASPD and comorbid cocaine dependence. However, CBT plus 'treatment as usual' was not better than control conditions for out-patients with recent verbal/physical violence. Mechanisms of change seem to be cognitive restructuring and behavioural activation. However, studies show considerable variation in measurement methods, comorbid disorders and demographic variables.

Schema-focused therapy

Schema-focused therapy (SFT) is an integrative therapy that draws on several approaches, such as cognitive, behavioural and psychodynamic therapies (Young 2003). Like CBT, the basic framework of SFT posits that people organise the world around them, including their interpersonal relationships, in schemas. SFT focuses specifically on early maladaptive schemas (EMS), which are hypothesised to originate from unmet emotional needs in childhood. In adulthood, when an EMS is triggered, this can cause powerful negative emotions.

In the original treatment protocol, the focus was placed on addressing EMS in therapy. However, those affected by a (severe) personality disorder switch rapidly between emotional states, which makes discussing the underlying schemas difficult. Furthermore, direct discussion of the EMS can be painful for the patient. Schema mode work was developed specifically to address these issues. Most of the attention in therapy is directed at schema modes, which flow from the underlying schema, but also reflect thoughts, emotions and behaviours that are present in the current situation. Schema modes are more state-like, whereas schemas are more trait-like and are part of the person's character. Within a warm therapeutic relationship, the therapist can effectuate change through therapeutic techniques. These include, for example, 'limited reparenting' and 'empathic confrontation'. In the first, the therapist establishes a secure attachment by doing what they can – within the bounds of a professional relationship – to meet the patient's unmet childhood needs. In empathic confrontation, the therapist repeatedly shows the patient that they have the patient's best interest at heart and have good intentions when confronting maladaptive-mode behaviours. A number of techniques are available to the therapist, including both the experiential technique of imagery rescripting and behavioural exercises. In imagery rescripting patients are guided to visualise past traumatic or distressing experiences linked to their EMS and schema modes. The therapist helps the patient reimagine the scenario in a way that alters the outcome, addressing the emotional needs that were unmet at the time. Behavioural techniques are designed to

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help patients modify the behaviours that reinforce their maladaptive EMS or schema modes.

Schema therapy is quite a long-term therapy that has been shown to be effective in reducing symptoms in people with personality disorders in various contexts. Effectiveness has mostly been shown for those with borderline traits but there is also evidence for patients with avoidant, dependent, obsessive–compulsive, histrionic, narcissistic and paranoid traits (Bamelis 2014). The mechanism of change seems to be the working through of childhood experiences and unmet emotional needs through reimagining techniques. These studies provide initial support for the effectiveness of schema therapy in treating personality disorders, particularly borderline personality disorder. However, one of the main limitations is the heterogeneity of the studies in terms of study design, sample characteristics and outcome measures.

Mentalisation-based therapy

Mentalisation-based therapy (MBT) was developed specifically for individuals with borderline personality disorder (Bateman 2018). The theory behind MBT rests on the process of mentalisation: people have ideas about the mental states of other people with whom they interact. The hypothesis is that those with borderline personality traits have an anxious, insecure attachment style and have not developed a robust capacity to mentalise within interpersonal contacts. Their attachment to others is inappropriately intense, with hyperactivation of the attachment system, and they have difficulty judging the trustworthiness of others. The aim of MBT is therefore for the individual to recover their mentalisation capacity, and not necessarily to gain insight. Therapy focuses on the present and does not delve into the past unless past events have a direct influence on the current state of the individual's life. The hypothesised mechanism of change in MBT is that the patient can, through the secure attachment with the therapist, safely explore the mind of another person. Within the MBT framework, the loss of mentalisation capabilities or slow recovery of these capabilities should signal sensitivity of attachment in the patient.

As with other therapies, MBT starts with an assessment phase during which the exact impairments in mentalisation are examined, as well as the attachment contexts in which these impairments surface. Treatment typically consists of individual and group sessions, crisis planning and integrated psychiatric care.

A systematic review found that MBT achieved either superior or equal reductions in psychiatric symptoms associated with borderline personality disorder and its comorbid disorders compared with other treatments (Vogt 2019). However, not all studies included in the review were of good quality. For example, studies commonly violated quality standards, such as in the reporting of *P*-values and effect sizes.

Dialectical behaviour therapy

Dialectical behaviour therapy (DBT) originated because the traditional CBT protocol could not be used with individuals who were chronically suicidal (Linehan 2014). A couple of fundamental adaptations of CBT formed the basis of DBT. The first step was to add 'radical acceptance' – the patient's full acceptance of their current situation, functioning and capabilities. Next, the therapy was divided into components – group-based skills training, individual (one-to-one) sessions, between-session phone coaching/support and (not involving the patient) the regular consultation group, where the treating team meets to discuss their practice – each with a specific focus. An important characteristic of DBT is that the therapist strives for a balance between acceptance and working towards change. Next, a number of mechanisms of change are hypothesised to be unique, such as the fact that validation is explicitly part of the therapist skill set, a high degree of therapist disclosure, targeting both primary (such as suicidal behaviour) and secondary problems (such as inhibited grieving), and between-session phone support.

DBT is inclusive in the sense that it aims to include patients with all levels of problem severity or complexity. Like other treatments, DBT consists of several phases. In the first phase, the aim is to decrease suicidal ideation and behaviour and to stabilise the patient. In the next phase, the treatment is aimed at replacing quiet desperation with non-traumatic experiencing of emotions. Phase three aims to achieve 'ordinary' happiness and unhappiness, similar to that in people not suffering from mental disorders. In this phase, there is also attention to reducing remaining problems of living. Finally, phase four aims to resolve feelings of incompleteness and to strive for a sense of joy. Furthermore, mindfulness to achieve acceptance takes a central role in DBT.

DBT has been most extensively studied in the context of borderline personality disorder, where it has consistently shown significant efficacy. For example, meta-analysis has shown it to be effective in reducing the use of psychiatric services and self-directed violence in patients with borderline personality traits, and in reducing substance misuse-related problems, which are frequent comorbid disorders in patients with personality disorders (DeCou 2019). But even though DBT is one of the most widely studies treatments for (borderline)

personality disorder, most studies only examine the effects of the first phase of treatment.

Transference-focused psychotherapy

Transference-focused psychotherapy (TFP) (Kernberg 2008) is based on object relations theory and was originally developed for individuals with borderline personality traits. It is hypothesised that in healthy personality development, the mental representations of the self and others become increasingly differentiated and integrated. In individuals affected by a personality disorder, these various sides are not integrated, which can lead the individual to use primitive defence mechanisms and to have an inconsistent view of the self or others and difficulty differentiating between internal and external experiences. The aims of TFP are to reduce self-destructive behaviour, including suicidality, facilitate behaviour control and increase affect regulation. Furthermore, TFP aims to improve relationship quality and to alleviate negative effects of the personality disorder on the ability to pursue life goals. The therapeutic alliance and transference are important in TFP.

Treatment according to the TFP protocol consists of three phases. The first phase is the contract phase, where the therapist and patient discuss what their relationship looks like, what rules apply to each of them and with which problems and at what times the patient can contact the therapist outside of planned sessions. Next, a diagnostic phase follows, where any affected internalised object relations are identified. The next phase allows for elaboration of these object relations and how these are represented in the patient–therapist relationship through transference and countertransference. In the final phase of treatment the focus is on integrating the various aspects of the self. With TFP, there are usually two one-to-one sessions a week and treatment lasts approximately 2 years, although treatment duration is not specified beforehand.

TFP has been shown to be successful in increasing reflective functioning in people with borderline personality organisation and in those with antisocial personality traits (Stern 2017). Mechanisms of change seem to be the intensive focus on the transference relationship. The number of studies on TFP is relatively limited compared with other forms of therapy. Also, they have significant limitations, such as large differences among outcome variables, the use of multiple measurement instruments and research methods, and relatively small sample sizes across studies.

Emotion-focused therapy

As the name indicates, emotion-focused therapy (EFT) focuses on emotions, with the central premise that emotions themselves have an adaptive potential, which can evolve into problematic emotional states (Pos 2007). EFT is based on six key values. These include the idea that experiencing forms the basis of thought, feeling and action, that humans are fundamentally free to choose their actions and words, and that a person as a whole is more than the sum of their parts. According to EFT, differences between individuals should be tolerated or even celebrated, as people function best in the context of authentic interpersonal relationships and people have a tendency towards development and growth. The goal of therapy is to help patients identify, experience, explore and find meaning in their emotions. They are helped to transform or manage their emotions. The hypothesised mechanism of change is awareness, regulation, reflection and transformation of emotion within the context of an empathetic relationship.

EFT is primarily conducted in individual settings, but it can also be applied to systemic therapies such as couples therapy. EFT is typically given once a week and can be both short or long term, depending on the complexity presented, and is generally successful in achieving change over the course of therapy in a wide variety of patient populations.

One of the primary limitations of EFT is the relatively limited research base, particularly in the context of personality disorders other than borderline personality disorder. A small study by Goldman et al (2005) indicated that EFT led to significant reductions in borderline personality disorder symptoms, particularly emotion dysregulation, impulsivity and interpersonal difficulties. When compared with CBT or psychoeducation, EFT generally shows a larger effect than the other two in patients with negative affectivity (Babapour 2023).

Cognitive analytic therapy

Cognitive analytic therapy (CAT) draws on elements from psychoanalytic, cognitive and personal construct theory and is time-limited. The core concept in CAT is that every child learns to internalise interpersonal experiences, for example with a parent (Ryle 2004). Reciprocal role procedures (RRPs) are internalised structures of the self and relationships. In those who develop a personality disorder it is hypothesised that the RRP structure is faulty. The hypothesis is that, similar to a child learning new processes from experiences, a therapist can also teach a patient new structures. Within CAT there are three specific aims, which are called the three Rs: reformulation of the patient's problems, recognition of disadvantageous patterns of cognition and emotion and relating these to an identifiable cause, and revision of these problems by collaboration between the therapist and patient. In CAT,

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written letters are used during the process of reformulation. CAT is brief, with treatment typically being offered once a week for 16 to 24 weeks.

Although most studies researching the effectiveness of CAT are small-scale and conducted in complex clinical populations (for example with acquired brain injury or dissociative identity disorder), it seems to be effective for a range of mental health problems, from depression to dissociative disorders and borderline personality disorder (Calvert 2014). One of the primary limitations of CAT is the relatively limited research base compared with other therapies. Although there is promising evidence supporting CAT's effectiveness, particularly in treating borderline personality disorder, more research is needed to establish its efficacy across a broader range of personality disorders. Mechanisms of change seem to be its structured approach and focus on relational patterns.

Systems training for emotional predictability and problem-solving (STEPPS)

Systems training for emotional predictability and problem-solving (STEPPS) (Blum 2002) combines CBT elements and skills training, and has been developed specifically for borderline personality disorder. The STEPPS programme views borderline personality disorder as a disorder that is characterised by a defect in an individual's internal ability to regulate emotional intensity. STEPPS is a 20-week manual-based group treatment which is primarily aimed at the acquisition of specific emotional and behavioural management skills.

There is limited empirical evidence for the effectiveness of STEPPS in people with borderline personality disorder. For example, Boccalon and colleagues (2017) demonstrated that it led to significant improvements in emotion regulation, interpersonal functioning and overall quality of life. Mechanisms of change seem to be the focus on psychoeducation and emotions and problem-solving skills. This study showed that patients receiving STEPPS or treatment as usual both showed improvements in negative affect, mood and global functioning. If we take this into account, the added value of STEPPS seems to be rather limited. However, no effect sizes were reported, which makes it impossible to sort out the specific effect of the STEPPS programme.

Good psychiatric management

Good psychiatric management (GPM) consists of flexible guidelines on attitudes to adopt when facing patients with a borderline personality disorder. Its basic principles are to offer psychoeducation, not overreact, be cautious, value the therapeutic relationship, convey that change is expected, foster accountability, maintain a focus on life outside of treatment and be pragmatic (Gunderson 2014). Similar to all other therapies for borderline personality disorder, it relies on a specified formulation of the disorder's symptoms as arising from interpersonal hypersensitivity. It uses this formulation to dynamically describe typical patterns of self-concept and interpersonal issues that drive the instability defining the general personality dysfunction characteristic of the disorder. Recent adaptations of GPM have been proposed for narcissistic personality disorder and obsessive–compulsive personality disorder, with development of similar dynamic models for both.

Research into GPM has generally supported its effectiveness, particularly for borderline personality disorder. Gunderson and colleagues (2018) state in their review that GPM was associated with significant improvements in patients' symptoms and functioning. Links & Ross (2024) also state that these patients can benefit from GPM. Other randomised controlled trials showed that its effects and lasting characteristics on patients equalled those of DBT (McMain 2009, 2012). Mechanisms of change seem to be the focus on psychoeducation, focus on practical issues and symptom management. These results should be interpreted with caution, given that research on the topic is scarce.

Common factors in personality disorder treatment

There is increasing evidence for the effectiveness of various psychological approaches for patients with personality disorders. For example, DBT has demonstrated effectiveness in reducing suicide attempts, depression and self-injurious behaviour in patients with borderline personality traits. Also, studies on SFT and MBT report improvement in personality disorder symptoms and global functioning over the course of treatment. These findings demonstrate equivalence of treatments, meaning that the outcomes of clinical trials are quite similar across approaches. There are several possible explanations for this.

First, studies may have failed to detect differences between approaches owing to research design factors such as the number of participants included or the nature of the comparison group. Second, although group-level changes suggest treatment equivalence (i.e. no difference between therapy approaches), this does not mean that therapies also have similar effects at the individual level. Different treatments can work in different ways in different patients. Broader evaluations of treatment impact are needed; outcomes should go beyond specific symptom reduction alone and should examine

individual change. A third possible explanation is that much of the variance in treatment outcomes is likely to be due to common factors (i.e. factors that are universal across treatment approaches) rather than specific elements of the therapy.

This third explanation was first suggested by Saul Rosenzweig in the 1930s, who stated that some implicit, common factors were perhaps more important than the methods purposely employed when explaining the uniformity of success of seemingly diverse methods (Rosenzweig 1936). Frank (1971) developed a common component model advocating four common factors in psychotherapy: a confiding relationship; action-oriented treatments (as they generally attract social approval); a therapeutic rationale that explains a patient's problems; and particular tasks and procedures to solve these problems. Subsequently, other authors have proposed further sets of common factors (Asay 1999). On the basis of the literature, we present four common factors that are robustly related to outcome across therapy approaches and populations and are associated with lower drop-out from treatment.

Prochaska & DiClemente (1983) proposed a transtheoretical model of change that focuses on the individual's decision-making. It consists of five stages. During the precontemplation stage, the individual has no intention to change in the near future, and typically denies the need or ability to change. During the contemplation stage, the individual thinks about changing and acknowledges a need for change, but has no immediate plan to accomplish this. During the preparation stage, the individual develops a clear intention and plan to change. During the action stage, the individual takes active steps to accomplish change. Finally, in the maintenance stage, the individual has successfully changed and takes steps to prevent relapse. Patients in the earlier stages have a low treatment readiness, leading to higher risk of treatment drop-out (Soler 2008). Low motivation in therapeutic interventions is common in the treatment of people with personality disorders (Barnicot 2011).

Patient characteristics

Patients themselves have a substantial influence on the outcome of psychotherapy. Patient characteristics related to successful change include a strongly stated desire and genuine intention to change, few obstacles hindering change and the confidence to change (Feinstein 2015). Another factor that influences personality disorder treatment is the patient's expectations and hope. Generating an atmosphere of hopefulness and communicating the expectation of positive outcomes to patients have been shown to be associated with good therapeutic outcomes regardless of the intervention. Also, the patient's gender and culture are distinct common factors in personality disorder treatment outcome. Personality pathology may present differently in females and males (Sher 2015). For example, borderline personality disorder may be classified similarly across males and female, whereas the symptomatic expressions may be quite dissimilar across gender. Borderline traits in men are typically expressed outwardly – they externalise their feelings and behaviour – whereas females tend to express their symptoms inwardly. Finally, treatment motivation predicts positive treatment outcome in people with personality disorders because motivation influences them to look for treatment possibilities, follow treatment instructions and make long-term changes. A person might be motivated to recover from, for example, an addiction, but might not seek treatment to help them do so (Kelly 2014).

Therapist characteristics

Studies have shown that the therapist has an effect on the outcome in psychotherapy. Approximately 5% of outcome variance is attributable to the therapist (Lambert 2013). When therapists are interpersonally warm and empathic, patients respond more positively to the treatment and experience increased motivation. Conversely, therapists who fail to convey that they are really listening, or are rigid, critical, uninvolved or uncertain are more likely to have poor or negative alliances with their patients. A weak and unhelpful alliance also occurs if the therapist is overly structured, uses inappropriate self-disclosure, insensitively maintains silence or interprets any transference in the room too intensely. Therapeutic outcome may also depend on the (perceived) competence and training of the therapist (Fairburn 2011).

The therapeutic alliance

The relationship between therapist and patient is often referred to as the therapeutic alliance or working alliance, and is a common factor in all psychotherapies for personality disorders. The therapeutic alliance might be seen to consists of three components: the emotional bond between the patient and therapist, the consensus between the therapist and patient about the goals of therapy, and their agreement on the tasks that make up the therapy (Horvath 1994). Research shows that the therapeutic relationship accounts for up to 30% of the variance in psychological treatment outcomes (Horvath 2011). Furthermore, the quality of the therapeutic alliance early on in treatment, as judged by both patient and therapist, predicts drop-out from treatment. This is important as the

drop-out rate among patients with personality disorders can be very high, with rates up to 67% (Wnuk 2013).

Social factors

Family and social inputs should also be considered, both in the aetiology and therapy, because of their profound impact on individuals' psychological development and functioning. Family dynamics, such as patterns of communication, attachment styles and parental behaviours, can shape the development of maladaptive personality traits and coping mechanisms. In therapy, incorporating family and social inputs can enhance treatment efficacy by addressing relational patterns and fostering supportive environments. Furthermore, social support networks play a critical role in reinforcing therapeutic gains and facilitating recovery, highlighting the need for a comprehensive approach that includes these external factors alongside individual-focused treatment.

Summary

Although common factors are important in all psychotherapies, no therapy is effective solely because of common therapeutic factors. Common and specific factors are complementary and should be viewed by their interaction so that specific treatment techniques are combined with the power of common factors to create a necessary condition for change. For example, McMain & Krysanski (2010) argue that elements such as the therapeutic relationship and patient expectations are particularly important in managing personality disorders and can often be more influential than specific techniques or approaches.

Future directions

In this article, we have discussed several specific and common factors in the treatment of personality disorders. However, continuing research that focuses exclusively on either specific factors or common factors does not seem effective for advancing the field. We propose three approaches that might be useful in the future.

Innovations in treatment delivery

As outlined above, psychological treatment for people with personality disorder is typically offered face-to-face and is delivered over a relatively long period of time in a classic individual or group format. Not all patients complete treatment – some discontinue therapy gradually or abruptly, whereas others do not even start, perhaps because of high costs, lack of health insurance, distance to the therapy location or stigma. After the global COVID-19 pandemic, many therapists are continuing to offer virtual sessions rather than returning to in-person sessions. Innovations in treatment delivery can overcome barriers to access and therapy engagement.

Research into treatment strategies and change mechanisms

In a classic article about strategies for psychotherapy in general, Paul (1967) raised questions about what treatment and by whom is most effective for a specific individual with a specific problem and under which set of circumstances. These questions are still relevant today with regard to treatment of personality disorders. Instead of continued head-to-head comparison of treatment approaches, we need to work together to answer these questions so that we can better tailor interventions/approaches to specific individuals.

Another fundamental question is the mechanism by which therapies for patients with personality disorders lead to change. Studying mechanisms of therapeutic change is important for several reasons. First, personality disorder treatment can have broad outcome effects. Knowledge on change mechanisms can clarify the connection between treatment (elements) and diverse outcomes. Second, if therapists understand the process that accounts for therapeutic change, they are better able to optimise this change. Finally, understanding how therapy works can help identify moderators and mediators of treatment. For example, if changes in cognitive processes account for therapeutic change, this finding might draw attention to the pretreatment status of related cognitive processes that might mediate or moderate treatment response.

Integrated framework for explaining and treating personality disorders

There is overlap in the theoretical underpinnings of psychological treatment approaches for personality disorders. For example, several approaches focus on cognitions/cognitive learning within interpersonal contexts and/or focus on emotional and/or behavioural regulation. There is a need to incorporate knowledge from diverse disciplines in psychology in order to adopt a unified, integrated framework that cuts across theoretical orientations and trait domains and age ranges, as also suggested by other authors (Johnson 2021). An integrated theory of personality pathology subsequently calls for an integrated approach to treatment of personality disorders: 'Comprehensive treatment requires a combination of interventions to treat the range of psychopathology typically associated with personality disorders' (Livesley 2005).

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Data availability

Data availability is not applicable to this article as no new data were created or analysed in this study.

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Author contributions

M.K.-d.V.: conceptualisation, original draft preparation and rewriting and final editing. M.C.: writing, review and editing.

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MCQs

Select the single best option for each question stem

1 Which premise is **not** part of the traditional CBT framework?
- a people have cognitive representations of their environment and 'the self'
- b cognitive representations are linked to the process of learning
- c to learn, an individual has to imagine their 'self' representation doing something repeatedly
- d cognition, emotion and behaviour all influence each other
- e CBT is intended to be short-term.

2 As regards schema-focused therapy (SFT):
- a in personality disorders, maladaptive schemas are the main focus of therapy
- b schema therapy for personality disorders is typically focused on schema modes
- c patients who have recovered only have healthy schemas and modes
- d SFT is one of the oldest form of psychotherapy for personality disorders
- e most techniques in SFT are behavioural.

3 According to mentalisation-based therapy (MBT), people with borderline personality traits:
- a have a disorganised attachment style compared with those without borderline personality traits
- b have no problems attaching compared with those without borderline personality traits
- c have an anxious attachment style compared with those without borderline personality traits
- d have a similar attachment style to those without borderline personality traits
- e have an insecure attachment style compared with those without borderline personality traits.

4 Which of the following explanations is unlikely to contribute to the finding that outcomes of clinical trials have shown similar results across different therapeutic approaches?
- a therapists were not adequately trained to properly effectuate nuances between different approaches
- b study factors (such as research design or sample size) led to a failure to detect differences
- c much of the variance in outcome was due to common factors (i.e. factors that are universal across treatment approaches)
- d much of the variance in outcome was due to specific elements of individual therapies
- e therapies have different effects at an individual level, which were not detected by examining symptoms at the group level.

5 We propose the following approach for the future of personality disorder treatment:
- a investing in more research examining effectiveness in various populations
- b continuing to do research that solely focuses on common factors in personality disorder treatment
- c investing in a strong patient–therapist bond, innovations in treatment delivery and research into treatment strategies and change mechanisms
- d innovations in treatment delivery, research into treatment strategies and change mechanisms, and focusing on an integrated framework for explaining and treating personality disorders
- e increasing patient motivation before formally engaging in therapy, innovations in treatment delivery and focusing on an integrated framework for explaining and treating personality disorders.