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REVIEW

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Multimodal approaches to the treatment of personality disorder

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ABSTRACT

Introduction: Personality disorder is the most common of all psychiatric disorders and is best perceived as a diagnostic spectrum extending from no personality dysfunction to severe personality disorder. The position on the spectrum is determined mainly by problems in interpersonal social dysfunction, self-perception and awareness, and dangers to the self and others.

Areas covered: We examine psychological and psychodynamic treatments, pharmacotherapy, neuromodulation and other related approaches, environmental treatments, and therapeutic communities. Although many published studies refer to individual categories, these are now linked to the diagnostic spectrum in this review.

Expert opinion: There is some evidence that focused psychological treatments linked to problem solving (STEPPS), mentalization based therapy and dialectical behavior therapy, are successful in treating moderately severe personality disorder, especially regarding self-harm, but there is also benefit from well organized standard care that is similarly effective. There is no good evidence that drug treatment is of real value in personality disorder. Brain stimulation approaches have limited evidence. Psychodynamic approaches, environmental interventions, nidotherapy, and therapeutic communities appear to be of some value, but good data are few. Long-term studies of treatment effectiveness are few but some show that personality disorder can respond to treatment and remit.

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Personality disorder; pharmacotherapy; pscyhological treatments; review; adaptive therapies

1. Introduction

This paper represents a good opportunity to correct some of the common misconceptions about personality disorder. Very many people believe that it is a permanent disorder that scars a person for life, which it is ingrained and unchanging and that it leads to premature death. None of these is true. The subject has also been made unnecessarily complicated by a categorical diagnostic system that has failed practitioners, researchers and patients, and which has provoked unnecessary stigma [1].

In this paper we will, as much as possible, be looking at the treatments of personality disorder from the standpoint of the International Classification of Disease 11th revision (ICD-11), the recently published dimensional classification of personality dysfunction that has abolished categories in favor of a simple classification of severity that encompasses personality difficulty, mild, moderate, and severe personality disorder [2] and in which five domain traits, negative affectivity, dissociality, disinhinbition, detachment and anankastia, qualify each level of disturbance, with borderline added as a pattern specifier but not a diagnosis [3]. Borderline could not be identified among the trait domains [4] and so its inclusion could not be justified.

Obviously, past work has used old classifications, and they cannot be ignored in the context of treatment, but as much as possible past evidence will be mapped on to the current classification system. Some of the more recent work has a lower evidence base but is still relevant in the light of the new classification, which is also being used in a similar way in the DSM Alternative Model of Personality Disorder (AMPD) [5,6].

2. Search strategy

Searches in PubMed, the Cochrane Central Register of Controlled Trials, and Google Scholar were conducted up until the end of January 2025, and repeated in May 2025. Searches included varying combinations of 'personality disorder' and the treatment approach of interest and their analogous terms, for example, 'psycholog*,' 'talk*,' 'therapy.' No historical date limit was applied, but articles were limited to the English language. Articles assessed as low-risk of bias in recent meta-analysis were specifically reviewed, as were the articles cited by key papers examined for their contributions.

3. Drug treatment and brain stimulation

The rationale for using drugs in the treatment of personality disorders in some ways anticipated the new ICD-11 classification. Most early research ignored individual personality disorders and focussed on the dimensions of personality pathology, particularly affective instability, impulsivity/aggression, anxiety-inhibition, and cognitive-perceptual disturbances [7]. However, there were two major problems with this approach; the first was that despite the heuristic appeal of these dimensions, there was

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Article highlights

- Personality disorder is very common, and some degree of personality disturbance is present in most psychiatric patients.
- Categorical classification of personality disorder has failed, and a dimensional classification offers a better route to treatment.
- Despite widespread and sometimes indiscriminate use, drug treatment has not yet been shown to be helpful and its continued use may be related to confusion over core personality and comorbid pathology.
- Structured psychological treatments from trained therapists, including dialectical behavior therapy (DBT), mentalization based treatment (MBT), systems training for emotional predictability and problem solving (STEPPS), have been shown to be effective for a minority of people with personality disorder who are described as having borderline pathology; these are characterized by emotional dysregulation, anger, and aggression, but treatment for others has been conspicuously absent.
- There is growing evidence that good psychiatric care branded as structured clinical management (SCM) and good psychiatric management (GPM) is helpful and useful in less severe personality disorders and should be practised universally.
- Personality disorders are frequently associated intimately with mental state disorders (Galenic syndromes), and awareness of the personality pathology can help therapeutic practice in choosing interventions.
- More attention needs to be paid to adapting to personality disorder rather than fruitlessly attempting to change it, and strategies including planned environmental change and acceptance and commitment therapy deserve more development.

little evidence of their validity, and the same disillusion was found with the Research Domain Criteria (RDoC) classification of mental disorders [8]. The second was that although the idea was to study behaviors across all personality disorder categories, virtually all field trials involved patients with borderline personality disorder.

These problems were further compounded by the common comorbid associations of borderline personality disorder, a diagnosis that crosses into all domains of mental pathology. Pure borderline pathology is uncommon, and most frequent in women. In a recent Cochrane review, 15 of the 46 studies enrolled women only. Most randomized controlled trials (RCTs) were also small, less than 10% had a sample size of over 100 [9]. There are no widely agreed valid measures for outcomes for borderline personality disorder (BPD) [10] making meta-analytic reviews more difficult. Many studies have been funded by the pharmaceutical industry and yield less reliable results. Most studies report no evidence that any medications are effective, and the only two randomized trials that recruited over 250 patients showed absolutely no drug benefit [11,12]. It is therefore not surprising that the most recent reviews [9,13] conclude that no pharmacological therapy is effective in specifically treating BPD pathology or reducing the severity of BPD. Despite this evidence, many still point to authoritative sources to justify prescription.

What is perhaps not surprising is that despite this consistent evidence of poor efficacy, most patients with borderline personality disorder are taking drug treatments, as such patients are often desperate for immediate relief of their symptoms. A survey of services in the UK caring for people with BPD reported that 92% were prescribed psychotropic medication, usually more than one [14]. Although comorbidity was high and often given as the reason for prescribing, the study showed that prescribing patterns were similar between those with BPD only and those with a comorbid condition [14]. Indeed, recent meta-analytic evidence has further brought in to question the clinical value of pharmacotherapy for treating co-occurring depressive, anxious, and psychotic-dissociative symptomatology, with only low certainty evidence for small effect sizes available from trials, none of which were rated to be at an overall low risk of bias [15].

This discordance is reflected in treatment guidelines. The UK National Institute for Health and Care Excellence (NICE) 2009 guidelines state that 'drug treatment should not be used specifically for BPD or for the individual symptoms or behaviour associated with the disorder (for example, repeated self-harm, marked emotional instability, risk-taking behaviour and transient psychotic symptoms)' [16] (para.1.3.5.1), and the Australian National Health and Medical Council also concluded that pharmacotherapy is not effective in altering the nature and course of BPD. These bodies ensure that all those with a conflict of interest are excluded from representation. Although the World Federation of Societies of Biological Psychiatry guidelines [17] stated that there is evidence for antipsychotics, selective serotonin reuptake inhibitors (SSRIs) and mood stabilizers being effective for some BPD symptoms, the evidence was not included. Despite clear recommendations that drug treatment for personality disorders is not recommended others contradict this advice without providing evidence [18].

The ICD-11 classification of personality disorder will greatly expand the proportion of those with personality disorder seen in clinical practice and it is likely that most of these will have other mental disorders, sometimes so intimately related to personality disorder that they can be regarded as separate Galenic syndromes [19] and to have specific treatments accordingly. When prescribing drug treatments in those who have this type of comorbidity, it is wise to be more cautious in prescribing drug treatment as dependence and withdrawal problems are more common in the presence of a personality disorder [20].

The difficulty in recommending drug treatments for co-occurring symptoms in those with personality disorders was reinforced by recent reviews and meta analyses of pharmacological treatments and reinforced by evidence from the most recent studies [21]. In the treatment of very severe personality disorder, the antipsychotic drug, clozapine, had been found in clinical studies to be of value in preventing recurrent self-harm [22], but the only substantial trial to evaluate its effectiveness [23] had to be abandoned as insufficient patients were recruited. The absence of robust evidence does not prove no effects exist but suggest caution before prescribing medication.

Neuromodulation treatments have been explored for the management of BPD following evidence of abnormal frontal lobe activity in this population [24]. This has led to the development of specific interventions, particularly repetitive transcranial magnetic stimulation [25,26], that in preliminary studies suggest a positive effect in improving emotional control. Deep brain stimulation and ECT [27] have also been

claimed to be of value in this population but all reviews point out the absence of adequate randomized trials that would provide clearer evidence. Emerging pharmacotherapies include oxytocin [28], psychedelics [29] and ketamine [30] but these studies are as yet too small to demonstrate efficacy.

4. Special (modular) psychological treatments

4.1. Psychological treatments

Psychological treatments are recommended as the principal approach to the treatment of personality pathology in all national and international guidelines [31–33]. A number of recent, well-researched systematic reviews [34–36] are all in agreement that there is tentative evidence, but no more, that psychotherapies developed or adapted for personality psychopathology are probably helpful when compared to standard psychiatric care.

These reviews identify only around 30 randomized controlled trials that provide evidence for the roughly 10 discrete psychological interventions studied in two or more trials. Given the shared founding principles of some of these interventions, i.e. psychodynamic, or cognitive-behavioral style therapies, there is likely overlap in their content and 'therapeutic ingredients,' while content and delivery are constituted differently. A large number of single studies of other often novel modalities have been conducted.

As well as a very small number of studies, there are important methodological concerns which also limit what can be trustfully concluded from the studies conducted. Some of these methodological concerns are presented in Table 1, and specifically relate to the heterogeneity in caseness that the overwhelming majority of trials have involved categorical assessments of personality disorder or inadequate proxy measures of personality psychopathology such as self-report, self-harming behaviors, or service-use.

If it is the case that 'something psychological is better than nothing' in the treatment of personality disorder, then outstanding questions remain as to which patient is likely to benefit from each of the many psychological treatments and why? As has been seen in other areas of psychiatry, it is likely that personality traits [37], level of personality functioning or symptom severity [38] and co-occurring mental state disorders explain some of the variation seen in the outcomes from each of these therapies. A summary of the evidence in favor of each of these therapies and a summary of their evidence base is presented in Table 2.

4.2. Structured psychotherapies developed specifically for personality psychopathology

Dialectical Behavioral Therapy (DBT), Mentalisation Based Therapy (MBT), and Transference Focused Psychotherapy (TFP) were all devised within the last 30 years specifically as treatments to target what their developers saw as the core facets of borderline personality disorder. Each has since undergone adaptations to target features of some other categorical formulations of personality disorder, notably narcissistic and antisocial phenomena [69,70]. These three have emerged as the leading psychological treatments for personality psychopathology and are widely recommended in the guidelines [31] of developed countries by virtue of the number and rigor of the trials testing these therapies, which have generally speaking been better quality than for other psychotherapies to date.

4.3. Psychodynamic and psychoanalytic psychotherapies

Psychoanalytic psychotherapies have been the subject of only a handful of clinical trials among people recruited with circumscribed personality psychopathology [43], and yet historically the level of case-report evidence has been more extensive. The standards by which a psychoanalytic approach recruits people and chooses outcome measures are not analogous to contemporary psychiatric approach but are not necessarily less helpful.

Instead, brief psychodynamic, dynamic deconstructive psychotherapy (DDP), and interpersonal psychotherapy (IPT) are developments of adapted psychodynamic psychotherapies with an emerging evidence base for treating personality psychopathology, and each has in limited meta-analysis reported meaningful reductions in at least some of BPD symptoms compared to standard care or inactive control [36,71]. Newer integrative approaches are increasingly common, but the question of whether they adhere to the spirit of

Table 1. Methodological concerns with trials of psychological and pharmacological interventions targeting personality psychopathology.

(1) Defining case-ness: Patients recruited to different trials have very different assessment criteria for personality disorder 'caseness.' These include various requirements of the presence of several symptoms from categorical lists to proxy measures of personality psychopathology like self-harm events or service use.
(2) Outcome measures: There are notable differences in measurement of change in outcome between studies, sometimes corresponding to the way in which personality disorder was defined at recruitment.
(3) Inconsistent interventions: Significant variation in the content and delivery modality of psychological interventions which are discussed as if the same. (i.e. group vs individual vs mixed, or inpatient vs outpatient, number of sessions, online vs in-person).
(4) Concerns relating to high drop-out rates, poor treatment fidelity and uptake, particularly among individuals randomised to control conditions.
(5) *Unassessed confounders*: Because of the complex nature of personality psychopathology, psychiatric co-morbidities, physical health disorders, life events, social environment, among other factors are likely to have an impact on inclusion and their outcomes often go uncollected.
(6) Some evidence of an affiliation bias, that is, the institution which developed the psychological treatment is the only institution to test its effectiveness and the only ones to show superiority.
(7) A large predominance of female patients.
(8) Very few studies conducted outside of Europe and North America.
(9) Length of follow-up is in most cases is limited to a few months.
(10) Small sample sizes compared to trials among other psychiatric conditions.
(11) Too many secondary outcomes discussed and addressed as if they were primary.

Table 2. Psychological treatments evidenced for people with mental health difficulties relating to personality psychopathology. CEBM = Oxford Centre of Evidence Based Medicine, Level of evidence.

Psychotherapy	Description	Summary of evidence base (as of Jan 2025)
Structured psychotherapies developed for personality psychopathology		
Dialectical Behavioural Therapy (DBT)	DBT in its archetypal form is highly manualised and consists of both weekly group and individual sessions relating to four core skills: Mindfulness, Distress Tolerance, Emotion Regulation and Interpersonal effectiveness. Various re-formulations and re-combinations of skills have been trialed in shorter DBT protocols, termed DBT Skills Training (DBT-ST) as has been used as an adjunct to other therapies.	More than 10 RCTs from multiple countries, across different treatment settings, comparing DBT to inactive control conditions or other therapies. CEBM Level 1a. References to main trials [39–42]:
Mentalisation Based Therapy (MBT)	MBT aims to enhance mentalizing, a meta-cognitive ability of all humans to recognize and anticipate our own intentions (i.e. our feelings, needs, beliefs), and these intentions of others. Mentalizing is thought to be limited among people with BPD, and which is developed through MBT. MBT is delivered either in groups, individually or as a mix. As an integrative therapy, other psychotherapies particularly creative psychotherapies have adapted to target mentalization.	More than five RCTs from multiple countries, across different treatment settings, comparing MBT to inactive control conditions or other therapies. CEBM Level 1a. Main published trials [43–47].
Transference Focused Psychotherapy (TFP)	TFP is a psychodynamic approach which aims to help the patient to tolerate an awareness of all-good and all-bad split-off objection relations in themselves and others [48]. In its archetypal form, this twice-weekly therapy is delivered individually over months and years.	Fewer than five RCTs from multiple countries, across different treatment settings, comparing TFP to inactive control conditions or other therapies. CEBM Level 1a. Main published studies [49,50].
Structured psychotherapies adapted for people with personality psychopathology		
Cognitive Behavioural Therapy (CBT)	CBT aims to help the patient identify and resolve unhelpful patterns of thoughts, feelings and behaviors [51]. Work which adapts core formulation techniques and methods for people with PD focuses the therapy on targeting specific symptoms like emotional regulation or suicidality, or co-occurring features like depressive or anxious symptomatology.	CBT components feature heavily in other approaches to PD including DBT and STEPPS. Analysis of CBT outcomes on specific symptoms among people with PD have been conducted and show mixed results. CEBM Level 1a. Main trials [52–54]:
Cognitive Analytic Therapy (CAT)	CAT therapists collaborate with their patients to identify and reformulate unhelpful roles they might reenact in relationships with significant others. Full description [55]	Limited RCT data is available for CAT among people with demonstrable PD, although a greater number of less rigorous methodologies have been published. CEBM Level 1a. Main trials [56,57]:
Schema Therapy	Schema Therapy was initially developed for people specifically with symptoms of BPD, and works to help the patient identify moment-to-moment how our existing patterns of responding to environmental stimuli can be more or less helpful to getting our emotional needs met [58]	More than five RCTs comparing Schema Therapy with inactive controls or other therapies among people with PD have been conducted. CEBM Level 1a. Main trials [49,59].
Acceptance and Commitment Therapy (ACT)	ACT is a third-wave cognitive-behavioral therapy which is adapted to address symptoms through accepting difficult emotions and acting in-line with their core-values.	Limited RCT data is available for ACT among people with demonstrable PD, although a greater number of less rigorous methodologies have been published. CEBM Level 1b-. Main trials [60,61].
Psychoanalytic and Psychodynamic psychotherapies		
Psychoanalytic psychotherapies	Psychoanalysis and psychoanalytic therapies are often open-ended intensive psychological treatments which aim to bring to light and resolve those unconscious tensions in the patient which contribute to difficulties in their life.	RCTs of psychoanalytic therapies among people with personality disorder are limited in number and scope, case series are more plentiful. CEBM Level 2b.
Psychodynamic psychotherapy	Psychodynamic therapies work similarly through identifying links between past experiences and unconscious tensions and current emotions and relationship patterns. Psychodynamic therapies are commonly time limited.	More than five RCTs comparing varying formulations of psychodynamic psychotherapies have reported on comparison against inactive controls or other therapies. CEBM Level 1a.
Trauma-focused psychotherapies *adapted for people with personality psychopathology*		
Narrative Exposure Therapy (NET)	NET supports patients to reframe important life events within objective contextual information to form a less distressing and better functioning autobiographical understanding of oneself. Example [62]:	RCTs of NET among people with personality disorder are limited in number and scope and are conducted among people with co-occurring PTSD. No meta-analytic evidence is available. CEBM Level 2b.
Eye-movement desensitization and re-processing (EMDR)	EMDR developed as a therapy of reducing the impact of traumatic memories by recalling these memories while moving one's eyes and other bodily stimulations. Example [63].	RCTs of EMDR among people with personality disorder are limited in number and scope and are conducted among people with co-occurring PTSD. No meta-analytic evidence is available. CEBM Level 2b.

(*Continued*)

Table 2. (Continued).

Psychotherapy	Description	Summary of evidence base (as of Jan 2025)
Creative psychotherapies		
Art therapies	Art therapists use aspects of producing and consuming multimodal images to support the patient to understand and use their emotions and relationships [64].	Fewer than five RCTs comparing art psychotherapies to waitlist controls exist. CEBM Level 1b-.
Drama therapies	Drama therapies look to use role-play and expression to process otherwise indescribable emotion and work-through relationship difficulties. Akin to the other creative psychotherapies, elements of other approaches, particularly mentalization and schema therapies have been incorporated into some drama therapies [65].	Fewer than five pilot or feasibility RCTs comparing drama psychotherapies to waitlist controls exist. CEBM Level 2b-.
Music therapies	Music therapists use aspects of producing and consuming music to support the patient to understand and use their emotions and relationships [66].	No RCTs examining music therapy among people with personality disorders have been reported. Evidence limited to case-control and case series data. CEBM Level 3b.
Short-term psychological treatments		
Systems Training for Emotional Predictability and Problem Solving (STEPPS), and other brief therapeutic combinations.	STEPPS is a short-term group approach combining elements of psychoeducation and CBT style techniques to help people with PD resolve interpersonal conflicts. See main text	Fewer than five RCTs exist for STEPPS, across different treatment settings. Systematic review evidence exists. Of at least five alternative short-term combinations there are varying levels of RCT evidence. CEBM Level 1a.
Psychoeducation	Psychoeducation is the process of informing patients of their condition to help demystify their experience. The focus is commonly on diagnosis, symptoms, etiology, and treatment. Example [67].	Fewer than five RCTs have examined the benefits of psychoeducation interventions delivered as groups in remote and in-person formats. CEBM Level 1b.
Parenting interventions	Interventions specifically targeting new parents with PD have included teaching skills relating to effective parenting, emotional-regulation skills in parenthood, and techniques to improve bonding and the relationship with their child. Example [68].	Evidence is currently limited to feasibility trials. CEBM Level 1b-.

Legends: For more information: https://www.cebm.ox.ac.uk/resources/levels-of-evidence/oxford-centre-for-evidence-based-medicine-levels-of-evidence-march-2009.

psychodynamic psychotherapy or merely label themselves as such needs attention. Fonagy provides a more complete review [70].

4.4. Short-term psychological interventions for personality psychopathology

Short-term psychological interventions, usually defined as lasting fewer than 6 months, have recently become more popular treatment options, but are yet to be included in treatment guidelines [72,73]. In the most part, this is probably because of long-standing concerns that a therapeutic alliance takes times to build, and that relationship endings are thought to be particularly difficult for people with personality disorder, who generally require more therapy time to work through to a harmonious conclusion. Indeed, these concerns have received some support [74]. Yet many people with mild, albeit still disabling forms of personality disorder, which may have failed to be captured by categorical models but will be in the dimensional system, might be helped by short-term treatments. Naturally, shorter psychotherapies have the benefit of being scalable, and in light of a clear gap between the numbers with personality psychopathology who might benefit from an intervention and those who actually receive it, these options offer great advantage. In some care models, people with more severe personality psychopathology or those not responding to short-term interventions may then be offered longer-term treatments [75], such as the more intensive therapies.

Short-term structured group programs of varying content have been developed and tested by several research groups. These have included as components skills-training focused on specific symptoms of borderline personality disorder like emotion regulation and interpersonal difficulties, the primary example being Systems Training for Emotional Predictability and Problem Solving (STEPPS) [76–78], which has become very popular in some settings. An interesting aspect of STEPPS is that those found to benefit most had a high level of symptoms and more comorbid pathology symptoms [79], factors normally associated with a poor outcome.

4.5. Other psychotherapies adapted for personality psychopathology

Special mention should be made to other similar interventions that have been subjected to randomized trials, including adapted forms of cognitive behavior Therapy (CBT) [52–54], Cognitive Analytic Therapy (CAT) [55–57] and Schema Focused Therapy [58]. Most of these studies have been with patients diagnosed with borderline personality disorder, and although a wide range of outcomes have been included, these do not always include personality psychopathology.

5. Selecting a psychological treatment

Despite much comment, there are not enough studies to make robust head-to-head comparisons between psychological treatments [36]. What is more, while there is an indication that some therapies might be preferred for specific secondary or symptom specific outcomes, these are very

few. Perhaps, more importantly, there is concern that the acceptability and feasibility of these treatments can vary greatly and sometimes lead to conflict [80]. Much of the current literature is devoted toward the identification of those who might be most suited for, and less likely to drop out from specific therapies [36].

Perhaps to improve acceptability, combination treatments are increasingly proposed, principally with the 'add-on' of limited DBT skills training, usually to established psychodynamic therapies. These have been the subject of a handful of trials, with some indications of benefit [36]. Successful combination between therapeutic community treatments and other psychological approaches have been published [81,82].

Length of treatment is another important facet of care, and with only a few direct comparisons for PD among single studies [83]. Six months versus 12 months of DBT was not meaningfully different nor was 5 months to 14 months of MBT [84]. Even longer-term psychodynamic treatment appears to have greater benefit in one comparison of the treatment of depression combined with personality disorder [59].

Most guidelines on the treatment of personality disorder recommend the assessment and treatment of co-occurring mental state disorders such as anxious, depressive, trauma-related, psychotic, and eating symptoms or substance misuse [31,33]. In the light of recent evidence suggesting that pharmacotherapy is not particularly helpful as treatment for co-occurring symptoms [15], a further review with a refocus on psychological interventions treating Galenic syndromes is warranted. Few of the psychological therapies adapted for personality psychopathology choose a primary outcome in advance, and it is difficult to know whether symptoms, behavior, or other aspects of personality pathology are most helped. Moreover, it is quite likely that many established interventions focused on depressive, anxious, and trauma-related symptomatology may lead to improvement in personality psychopathology also although this is rarely measured as a secondary outcome.

6. Summary of current favored psychological treatments

As is often the case, treatments which lend themselves to being tested by clinical trial methodologies, because they can be funded, delivered consistently and are replicable, can recruit adequate sample sizes to power robust statistical analysis, could ensure blinding and so on, find themselves to be more studied and therefore more likely to be recommended in guidelines. Unlike studies of pharmacotherapies which are suited to this kind of trial, trials of psychotherapies have long run into methodological difficulties and some more than others, particularly psychoanalytic psychotherapies, will need to develop robust outcome assessment and process evaluation measures if they are to be soundly recommended. As yet there is not the convincing evidence to recommend one psychological treatment over another for any group of patients. The summary of the main studies is shown in Table 2.

7. Structured clinical management and good psychiatric management

Because there have been many criticisms of treatment as usual (TAU) as a control treatment in trials of psychological treatment, researchers have tried to introduce a more appropriate active control in two-arm trials. The two most commonly used for studies of personality disorder are Structured Clinical Management (SCM) and Good (or General) Psychiatric Management (GPM). This concern arose from an early trial of DBT in which general psychiatric management (GPM) produced the same degree of benefit as DBT [40] and similar results were found at two-year follow-up [85]. Both SCM and GPM follow what most clinicians would regard as sound community treatment, including authenticity and openness in interviewing, empathy, validation, positive regard, and advocacy, together with more specific interventions such as problem-solving skills, techniques for regulation of mood and impulse control, and addressing self-harm with robust crisis planning [86,87].

Both GPM and SCM are now advertised as evidence-based treatments and courses lasting many weeks are available for them. But, it is not exactly clear where they stand in comparison with good ordinary practice, with which they have never been compared, or with the more specialized treatments such as MBT and DBT. The evidence from trials suggests they are probably effective and sometimes superior to the more complex treatments – in one study, SCM was associated with fewer episodes of serious self-harm than MBT [46] – but without a good comparison with good standard care their value is moot.

8. Adjustment and acceptance therapies

Most of the therapies for personality disorder still adopt the premise that personality disorder is an illness like other mental disorders, and treatments are aimed at removing its unpleasant and unwanted features. This may be true of emotional dysregulation, which has never been of value to human function, but not of the five trait domains in ICD-11, all of which have been of value in evolutionary development. Many have failed to recognize that basic personality traits do not change over the course of therapy as they are intrinsic to the person and persist in a very similar form throughout life [88]. Many of the specific components of specialized psychological treatments are focused on emotional instability and are not relevant to other elements of personality dysfunction.

For other domains of personality disorder, there has been a growth in approaches that promote adaptation and acceptance to recognized problems of personality without the thankless task of trying to remove them. Acceptance and Commitment Therapy (ACT) concentrates on training people to accept unpleasant negative thoughts, feelings, symptoms, or situations without fighting them all the time. It also promotes more healthy ways of behavior that are in keeping with the person's values, hopes, and goals. It has been used primarily in the treatment of symptoms such as anxiety and depression but has also been used for personality disorder

[60,61], but there have been no substantive trials of its efficacy.

Severity of personality dysfunction changes over time even though underlying personality does not [89,90], and although this seems a paradoxical conclusion it is not. Disorder is shown when the personality clashes with the personal, social, or physical environment and when the environment is changed to a more favorable one the disorder will ameliorate or disappear altogether. The deliberate manipulation of the environment to make a better fit for the person with personality disorder is called nidotherapy [91,92] and has been shown to be effective and cost-effective in two randomized trials [93,94]. It has also been expanded to cover all pathology in the five domain traits of ICD-11 [95]. One of the advantages of the implementation of the ICD-11 classification is that less complex treatments for mild personality disorder and personality difficulty [96] can now be tested and introduced when shown to be effective.

In discussing the range of interventions for personality disorder, the first, of all of these, was the therapeutic community, the principles of which were excellently summarized by Rapoport [97] but which had its origins at Northfield Hospital in Birmingham during the Second World War. It has been difficult to get a good evidence base for therapeutic communities and many have closed, rightly or wrongly, because of perceived cost-ineffectiveness. Providing this service as day care may be a useful approach and has some evidence of effectiveness in trials [82,98].

9. Expert opinion

Although, personality disorder is very common, its treatment has been neglected. Too much attention has been given to intensive psychological treatments, which though effective, can only be given to a very small proportion of those with personality disorder because their requirements are so exacting. Almost 75% of patients with personality disorders who are not currently covered by the term 'borderline' are neglected. A complete refocus of treatment is needed and can be examined with the aid of the dimensional classification system. This approach has already shown that personality dysfunction is very common, with almost all patients in psychiatric care having some personality pathology that has a clear impact on outcome. This pathology needs to be recognized early in assessment and should guide intervention, both directly in addressing problems in relationships, and indirectly in adapting treatment strategies for comorbid mental state pathology. The advantages of a dimensional system include tailored interventions based on severity of pathology, recognition of lower levels of pathology that should still guide treatment, a more likely understanding of the place of drug treatment, and a much greater awareness of the neglected domains of personality pathology including avoidance, detachment, and obsessionality that are only now beginning to be therapeutically tested [99].

The new dimensional system of classification has refocused attention on the large proportion of people with personality disorder whose problems are currently ignored. Those with primary emotional dysregulation are likely to be helped by structured psychological treatment, but this represents a few drops in the therapeutic ocean. The current preoccupation with the wider heterogeneous condition called borderline personality disorder has captured too many other conditions in its snare, leading to an expanding range of treatments, most of them of limited value unless there is comorbid pathology, and where the effective ones require high therapeutic intensity.

The neglect of other personality pathology cannot continue. Most patients in psychiatric care have personality pathology, which predicts poor outcomes [100,101], yet this is ignored, and people are sometimes instead labeled 'treatment-resistant.' Once the categorical system of diagnosing personality disorder is abandoned, a proposal that seemed unlikely 10 years ago but now seems imminent, proper attention can be given to the very wide range of pathology within the dimensional system. Although diagnosis is only a guide in this endeavor, it is important, as the current diagnostic system hinders understanding by incorporating irrelevant comorbidity that confuses and muddles both research and practice and prevents the advance of science.

The removal of borderline personality disorder from diagnostic practice is sorely needed as it is a stigmatic label reflecting an unhelpful response to relational conflict. All practitioners need to be able to detect personality pathology early in assessment and use it to fashion their treatment plans, and in most cases lead to well-ordered, systematic, shorter planned psychological treatments, and to appropriate ancillary drug treatment if it is evidence-based. This help is needed in accepting and adapting to personality difficulties without the need for intensive interventions, and research endeavor is desperately needed to establish their efficacy.

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