Treating Personality Disorder: Evidence and Systems

THE TALKING THERAPIES UK PRACTITIONER SERIES



Treating Personality Disorder: Evidence and Systems

The evidence-based treatments and the case for integration

Advanced level · 14 hours of continuing professional development

TALKING THERAPIES UK

First edition · 2026

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First edition, 2026.

This manual accompanies the Treating Personality Disorder: Evidence and Systems course in the Talking Therapies UK Digital Classroom, from which its content is drawn and against which it is kept current.

Revision 7. This printing was set on 10 November 2026 from the course as it stood that day.

A note on the clinical material. Every case in this book is a fictional composite written for teaching. No real person appears in it, however disguised. Nothing here constitutes clinical supervision, and nothing in it replaces the judgement of a qualified practitioner working within their competence, their professional body's code and their local governance. Where guidance is cited it was current at the date of this edition; readers must check the standing of any guidance before relying on it.

Set in Poppins and Roboto, the Talking Therapies UK typefaces. Figures drawn by the Talking Therapies UK teaching-diagram engine.

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How to use this manual

This advanced integrative course equips experienced clinicians and service leaders with the conceptual and practical tools to deliver evidence-based personality disorder interventions within real-world systems. The curriculum begins by dissecting the four major structured treatments—Dialectical Behaviour Therapy, Mentalisation-Based Therapy, Schema Therapy, and cognitive approaches—examining exactly what each modality targets (for example, affect dysregulation, impaired mentalising, maladaptive schemas, or maladaptive cognitions), the strength of the empirical support for each, and their respective limitations. Learners will critically appraise randomised controlled trials, meta-analyses, and service-level outcome data, enabling them to distinguish between first-line, second-line, and adjunctive interventions and to match modality choice to patient need with precision.

The second half shifts from individual technique to system design, interrogating why fragmentation persists across British mental health services despite decades of guidance. Participants analyse the organisational, commissioning, and workforce barriers that sustain siloed pathways, and explore how these structural issues translate into poorer continuity of care and disengagement for people with personality disorder. Building on this analysis, the course presents the Integrated Personality Treatment Framework (IPTF) as a stage-based, stepped-care roadmap that synthesises the strengths of each evidence-based modality into coherent, service-level pathways. Through case-based discussions and service mapping exercises, learners will translate the IPTF into actionable plans—auditing existing pathways, identifying gaps, and redesigning referral and care-coordination processes to deliver cohesive, recovery-oriented treatment.

By the end of the course, participants will have not only deepened their clinical fluency in the evidence base but also developed the strategic insight required to advocate for and implement IPTF-aligned systems within their organisations, thereby bridging the gap between individual treatment fidelity

and systemic transformation.

This manual is the written form of a course taught in the Talking Therapies UK Digital Classroom. It is set at advanced level and carries 14 hours of continuing professional development for practitioners who complete the accompanying course and its assessment.

It is written to be read in order. Each part opens with what it is for; each chapter teaches one idea to a working depth and closes with the points worth keeping and a practice task that converts reading into something you do. The tasks are the part most often skipped and the part that most reliably changes practice, and several of them are designed to be taken to supervision rather than completed alone.

The figures are teaching diagrams rather than decoration. Each is the conventional form of a model you will meet in the literature and in supervision, drawn in one visual language across the whole series so that the shape of an idea is recognisable wherever it reappears.

Where a chapter draws on published work, the reference is named in the text and gathered in the further reading at the back. Terms of art are defined in the glossary, which is worth reading straight through once before you begin.

What this manual will leave you able to do

- Compare the evidenced treatments, including DBT, MBT, schema therapy and TFP, and their shared factors
- Apply general therapeutic principles for personality difficulty in any modality: consistency, coherence and continuity
- Design care pathways that avoid both neglect and iatrogenic over-intervention
- Work with the system around the client: crisis plans, admissions policy and team splits
- Hold staff dynamics: splitting, burnout and the pull to reject
- Evaluate long-term outcomes and argue for realistic, hopeful expectations

PART 1

Part 1: The structured treatments compared

Lessons 1 to 5 of the course.

CHAPTER 1

The structured treatments compared

The history of personality disorder treatment is a story of methodological rigour transforming a field once resigned to pessimism into one of structured, evidence-based hope. Over the last four decades, the development of manualised, structured interventions has represented the field's most significant achievement, shifting the paradigm from the vague and the experiential to the precise and the measurable. This lesson surveys the landscape of these structured treatments, not merely to catalogue their contents, but to understand the distinct theoretical mechanisms that drive them. A clinician who grasps these mechanisms can move beyond brand loyalty to clinical reasoning, selecting the intervention that best fits the patient's specific pathology and stage of change. The four pillars of this landscape are Dialectical Behaviour Therapy, Mentalisation-Based Treatment, Schema-Focused Therapy, and Structured Cognitive Therapy, each targeting a different core deficit while converging on a shared commitment to structure and risk management.

Dialectical Behaviour Therapy, developed by Marsha Linehan, stands as the most researched and empirically robust of the structured treatments. Its theoretical foundation is the biosocial theory, which posits that individuals with Borderline Personality Disorder possess a biological vulnerability to emotional dysregulation, which is then exacerbated by an invalidating environment. Consequently, the primary target of DBT is emotion dysregulation and the maladaptive behaviours it produces, such as self-harm and suicidal behaviour. The mechanism of change is the acquisition of concrete regulatory skills within a therapeutic relationship that holds the dialectical tension of acceptance and change. The structure of DBT is uniquely comprehensive, comprising weekly individual therapy, skills training groups covering mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness, telephone coaching for real-world application, and a therapist consultation team to ensure treatment fidelity. The evidence base is formidable, with randomised controlled trials consistently demonstrating reductions in self-harm, suicide attempts, and hospitalisation compared to treatment as usual, with long-term follow-up data indicating

that these gains are maintained. Crucially, dismantling studies have isolated the skills component as the active ingredient, confirming that the manualised curriculum is the engine of change.

In stark contrast to DBT's focus on emotion, Mentalisation-Based Treatment, pioneered by Peter Fonagy and Anthony Bateman, targets the collapse of mentalising under attachment stress. Mentalising, or reflective functioning, is the capacity to understand the mental states—both one's own and others'—that underlie behaviour. MBT operates on the premise that patients with Borderline Personality Disorder have the capacity to mentalise but lose it under states of high arousal, leading to a catastrophic failure to understand the other's perspective and a resulting sense of persecution. The mechanism of change is the restoration of the mentalising stance, a curious, non-judgmental, and arousal-managing stance that is cultivated through individual and group therapy. The evidence base for MBT is equally compelling, with Bateman and Fonagy's partial-hospital trials and subsequent outpatient replications showing significant reductions in self-harm, admissions, and service use. Notably, the eight-year follow-up data from the Fonagy and Bateman cohort represents one of the longest horizons in the personality disorder literature, showing that patients treated with MBT still had less suicidality and service use, and better functioning, than those given treatment as usual eight years after the start of treatment (Bateman & Fonagy, 2008).

Schema Therapy, developed by Jeffrey Young, shifts the focus to the enduring structures of personality, or schemas, and the mode states they generate. Young identified early maladaptive schemas—broad patterns of dysfunctional memories, emotions, and bodily sensations that develop from early experiences and coping styles. Schema therapy targets these deep-seated schemas through a combination of cognitive, experiential, and relational techniques, including imagery rescripting, chair work, and limited reparenting. The mechanism is the healing of the schema at a visceral level, rather than merely managing its behavioural output. The Dutch multi-site trial comparing Schema Therapy to a psychodynamic comparator showed strong recovery rates favouring Schema Therapy, and subsequent work has supported group formats for specific schemas. This approach is particularly suited for patients with entrenched, ego-syntonic patterns who are stable enough to engage in deep experiential work.

The cognitive approaches, rooted in the work of Aaron Beck, target the belief systems and conditional rules that drive behaviour. While standard CBT for personality disorder often struggles with the rigidities of the patient, structured cognitive variants extend the collaborative empiricism of standard CBT over a longer arc. These approaches focus on identifying and modifying the conditional rules derived from early experiences, such as ‘If I am perfect, I will be loved.’ A notable pragmatic entry in this space is Systems Training for Emotional Predictability and Problem Solving, or STEPPS, a 20-week group-based intervention that has trial support for symptom and functioning gains at modest cost. Alongside these four, we must name the fifth honestly: structured generalist care. High-quality, formulation-based, continuity-preserving care without a specific brand label often performs better than expected in trials, serving as a vital option when specialised treatments are inaccessible.

When read across this menu, a pattern emerges. The treatments differ most profoundly in their theory of the core deficit—whether it is dysregulated emotion, collapsed mentalising, entrenched schema, or distorted belief—and in the experiential depth of their methods. However, they converge on structure: every one is manualised, long-term, hierarchical regarding risk, explicit about the therapeutic relationship, and delivered by supported clinicians. Their trial populations overlap heavily, with Borderline Personality Disorder presentations dominating the evidence base, which is why the ICD-11 borderline specifier maintains a strong link to this literature. While their outcomes are not identical, they are more alike than different where they have been compared head-to-head.

To see how this matching logic earns its keep, consider a clinical example involving a family. The eldest brother, a man of twenty-six, presents with escalating lethality in his self-harm, having overdosed twice this year, and rages that have resulted in the loss of his housing. His presentation is dominated by negative affectivity and disinhibition, with a clear borderline pattern. The mechanism sentence for this patient is behavioural dyscontrol driven by severe emotion dysregulation. The match here is unequivocally DBT. The hierarchy of care in DBT exists precisely for this risk profile, prioritising life-threatening behaviours and crisis management. The skills curriculum addresses his deficits in distress tolerance and emotion regulation directly, and nothing deeper is safe to attempt while the lethality curve points upward. The chain analysis technique within DBT would be the

primary clinical tool here, mapping the antecedents and consequences of his self-harm to interrupt the cycle.

Contrast this with his sister, a woman of twenty-nine, who presents with no behavioural instability but a pattern of serial relationship collapses. She oscillates between idealisation and devaluation, perceiving a slight as evidence of contempt, followed by a fortnight of vengeful certainty. Her mechanism sentence names a mentalising collapse under attachment arousal; she loses the ability to mentalise the other person's perspective during conflict. The match here is MBT. A standard skills group would bore her and miss the engine of her difficulty. MBT's stance, or Stage Two mentalising work within an integrated frame, offers the rational offer. The focus would be on helping her to stay in her head, to observe her thoughts without acting on them, and to understand that her partner's behaviour is driven by mental states, not necessarily contempt.

Finally, consider their father, a man of fifty-five, who is rigid, joyless, and estranged from everyone. He has worked forty years in a job he detests and displays prominent anankastia, or obsessive-compulsive traits, with a detachment from others. His mechanism sentence names entrenched, ego-syntonic patterns and a punitive internal tribunal. No crisis technology is relevant to him, and the long game is schema-level. The match here is Schema Therapy. He requires the experiential reach of chair work to address the deprivation schema beneath his rigidity and the punitive mode that punishes him for any deviation from his rules. Limited reparenting might be necessary to heal the deficit in his early environment, a depth of work that neither DBT nor MBT is designed to provide.

One family, three mechanism sentences, and three different front doors. This survey is not about finding the 'best' treatment, but about finding the right treatment for the mechanism the formulation identifies. The clinical skill this lesson builds is matching: match to the dominant mechanism the formulation names, match to the stage of change, and match to the patient's capacity for depth. The integrated framework this course culminates in makes exactly this move, using DBT's mechanisms early, Schema and Mentalising work in the middle, and functional rebuilding late. The exercise that follows is to apply this logic to two people you know clinically, writing the mechanism sentence and the treatment match it implies with one sentence of justification each. The next lesson complicates the picture

honestly, examining what the trials do not show, who drops out, and why the common factors keep embarrassing the brands.

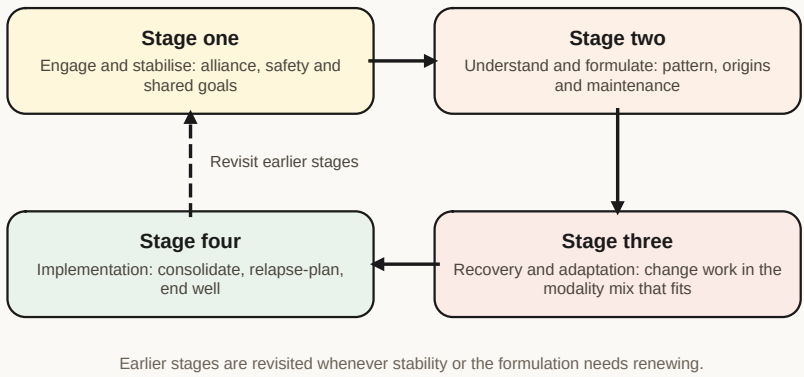


FIGURE 1.1 The IPTF pathway at a glance

The integrative pathway taught across the IPTF courses moves through four broad stages: engaging and stabilising, understanding and formulating, working for recovery and adaptation, and implementing gains so they hold in everyday life. Progress is cyclical rather than strictly sequential; earlier stages are revisited whenever the work requires it.

Points worth keeping

- DBT: emotion dysregulation and behaviour
- MBT: mentalising under attachment stress
- Schema therapy: enduring schemas and modes
- Cognitive approaches: beliefs and behaviour

PRACTICE TASK

Match each treatment to the mechanism it primarily targets.

CHAPTER 2

Evidence, limits and common factors

Every treatment in the last lesson works. That sentence, which would have astonished the field forty years ago, is now the consensus reading of the trials, and it is precisely why this lesson is needed, because the next question, which works best, for whom, and why, has answers that embarrass the brands, and a clinician who reads the evidence honestly will practise differently from one who reads only the abstracts.

Begin with what the trials genuinely establish. Against treatment as usual, the structured therapies reduce self-harm, suicidal behaviour, admissions and symptom severity, with effects that persist at follow-up; this holds across DBT, MBT, schema-focused and cognitive approaches, and the replication record, while uneven, is real. But press harder and the picture complicates in instructive ways. Head-to-head comparisons between active, structured treatments find differences that are small, inconsistent or absent: the landmark trial comparing DBT with general psychiatric management, well-delivered, structured, principle-driven care, found both arms improving substantially with little between them, and the pattern recurs wherever a brand meets a credible structured comparator rather than unstructured usual care. Effect sizes against strong comparators are moderate at best. Dropout runs from a fifth to a third across trials and higher in routine services, and the people who leave are disproportionately the most severe, most comorbid and most excluded, which touches the generalisability problem directly: trial samples, shaped by exclusion criteria, consent and research infrastructure, are systematically unlike the caseloads of ordinary services, and outcomes measured, often symptom counts and behavioural tallies, systematically under-represent the functional recovery, work, relationships, a life, that the longitudinal studies show lagging years behind symptomatic remission. None of this undoes the achievement; all of it disciplines the claims.

The common-factors reading organises these findings rather than merely deflating them. If structured, coherent, agreed-upon treatments outperform chaos but not each other, the active ingredients are likely to be substantially shared, and the candidates are well characterised. A coherent framework,

believed by both parties, that makes the difficulties intelligible; that is formulation. A strong alliance, monitored and repaired; the relationship the whole pathway has treated as instrument. Clear structure, expectations and hierarchy around risk; the frame. Active, engaged therapists supported against the work's known pulls; the team behind the therapist. Continuity long enough for attachment learning to occur; time. Each brand carries all of these, wrapped in a distinctive theory and technique set, and the honest reading is that the wrapper matters less than the parcel, with the sharpening that specific components do show specific effects where dismantled, DBT's skills training most clearly, so the strong version of nothing but common factors is also false. The clinical arithmetic that follows is the lesson's centre: brand technique unsupported by the common factors fails, the common factors delivered with conviction and structure succeed even unbranded, and the brands at their best are delivery vehicles that guarantee the common factors while adding mechanism-specific value at the margins.

For practice, the implications are direct. Deliver whatever you deliver with the structure the evidence rewards: explicit formulation, explicit frame, explicit crisis architecture, alliance attended to as data, supervision that supports the stance. Treat drop-out as the outcome it is, engagement failures are treatment failures, and the early alliance is the best predictor you own. Hold the brand loyalties lightly and the shared factors tightly, which licenses principled flexibility: the person who cannot use a group, the service that cannot staff a full programme, can still receive the parcel. And measure what matters: symptom counts for the trials' sake, but functioning, severity re-rated, a life accruing, for the person's.

The findings also settle a question every service argues about: what to do when the full brand cannot be delivered. The purist position, nothing but the complete programme is legitimate, reads the evidence exactly backwards. The trials' strong comparators, general psychiatric management, structured clinical management, good clinical care, are themselves the demonstration that the parcel travels without the wrapper: each was built deliberately from the common factors, formulation, frame, continuity, active stance, crisis architecture, supervision, and each held its own against the brands in fair fights. The service implication is a stepped architecture with integrity at every step: full programmes where severity and resources meet, structured generalist care as the evidence-bearing backbone everywhere else, and never the third thing the purist position accidentally licenses, which is

unstructured care delivered apologetically because the proper treatment was unavailable. The apology is the harm: a service that believes it is offering second-best delivers second-best, while the same staffing delivering the common factors with conviction delivers, on the trial record, most of what the brands deliver. The practitioner implication is personal: your allegiance debates matter less than your structure audit. Whatever you practise, the questions that predict your outcomes are the common-factor ones, does every person have a formulation they recognise, a frame they can predict, a crisis plan that runs without you, an alliance you monitor as data, and a supervisor who supports the stance when the work pulls at it. Answer those five well and the evidence says you are delivering effective treatment; answer them badly and no brand will save it.

For the field, the implications point one lesson ahead. If the treatments converge on shared mechanisms delivered through different theories, then the rational service offers the mechanisms in an organised way rather than franchising competing brands, matching technique to person and stage instead of person to whichever training the local team happens to hold. That is the argument for integration, and it has been building through every course in this pathway: the developmental account gave the difficulties one intelligible origin story, the dimensional model gave severity one intensity dial, this lesson gives the treatments one shared engine with modality-specific accessories. The next lessons take the argument into the world as it is, the British service context where fragmentation persists for reasons evidence alone has not cured, and then to the synthesis, the staged, integrated framework that this pathway's companion courses teach in full. Before moving on, complete the evidence exercise: write five sentences you could defend to a sceptical colleague, one on what the trials show, one on what they do not, one on drop-out, one on common factors, one on what your own service should change tomorrow. If the five sentences survive your own scrutiny, the survey has become judgement.

Going deeper: reading the trials like a practitioner.

Four habits of trial-reading turn this lesson's cautions into method. First, always ask what the control condition actually was, and when. Early trials ran against treatment-as-usual that sometimes meant almost nothing, and effect sizes shrank as comparators improved; the later head-to-head and specialist-versus-structured-generalist trials are the honest reading of what a

brand adds, and their answer, usually ‘something, but less than the early trials implied’, is not a scandal but a calibration. Second, ask what was measured and when. Self-harm frequency responds earliest and most reliably; emptiness, identity and relational capacity move later, less, and are measured less often; and follow-up attrition means the long-term curves are drawn from the people who stayed findable. A treatment can look transformative on the primary outcome while the life-as-lived outcomes are still under construction, which is exactly the gap the recovery literature and service-user movement keep pointing at.

Third, count the exits. Dropout in these trials commonly runs from a fifth to a third, dropouts are rarely random, and intention-to-treat analysis, while statistically proper, quietly averages the people the treatment lost into the treatment’s advertisement. A practitioner’s question is always ‘who leaves this treatment, and would my client be one of them’. Fourth, hold the allegiance and generalisability corrections: developers’ own trials outperform independents’ across this whole literature, and trial samples, screened for comorbidity and consent, are cleaner than any community caseload. None of this reading dissolves the good news; it locates it. The treatments work; their specific superiority over well-structured, formulation-driven, continuity-rich generalist care is modest; therefore the active ingredients are probably concentrated in what the credible treatments share.

That is why the common-factors list this lesson gives is not a consolation prize but an implementation target: a coherent model offered with conviction, a hierarchy for risk, scheduled reflective supervision, an explicit relational frame, and duration measured in years, delivered by a team that does not fragment. A service that cannot fund a brand can fund that list, and the trials’ own comparators keep proving the list is most of the medicine.

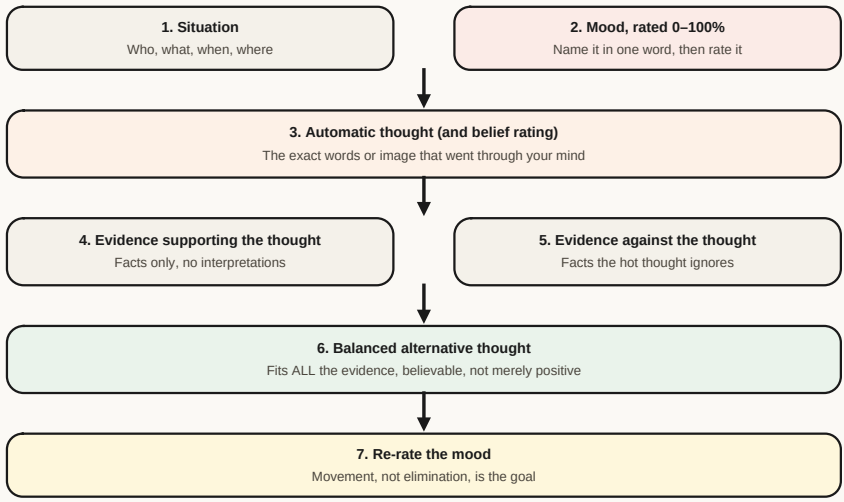


FIGURE 2.1 Working through a thought record

The classic seven-column thought record as a sequence: capture the situation and mood, catch the automatic thought, weigh the evidence on both sides, build a balanced alternative, and re-rate the mood. The learning is in the discipline of evidence before reassurance.

Points worth keeping

- Reading the trial evidence honestly
- Limits, drop-out and generalisability
- Common factors across treatments
- Why no single brand suffices

PRACTICE TASK

Name one limit of the evidence base for a treatment you use.