BJPsych | The British Journal of Psychiatry (2024)
225, 583–584. doi: 10.1192/bjp.2024.105

Commentary

Dosage effects of psychodynamic and schema therapy in people with comorbid depression and personality disorder: four-arm pragmatic randomised controlled trial: commentary, Mulder

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Keywords
Psychotherapy; depression; personality disorder.

Response

A recent comprehensive evaluation on the effects of psychotherapies and pharmacotherapies for mental disorders concluded that after more than half a century of research, with thousands of randomised controlled trials (RCTs) conducted, the effect sizes of treatment were limited, suggesting a ceiling effect for treatment research as currently conducted. The authors recommended a paradigm shift in research to achieve further progress.[1] They were less forthcoming about what this shift might entail.

The Kool et al[2] study at least attempts to shift the paradigm slightly. Rather than yet another head-to-head comparison of two psychotherapies in patients with depression, it varies the dose and intensity by comparing 25 with 50 individual sessions given over 9–12 months. In addition, rather than using patients with uncomplicated cases, the authors set out to recruit patients who had depression with one or more personality disorders. Such patients tend to respond less well to treatment in general[3] so it is plausible that they may be better served by a high dose of treatment as the authors note.

Whether more treatment leads to a better outcome is not a trivial question. Limited mental health resources need to be used wisely and the common assumption that more psychotherapy is better needs to be tested. It rarely has been, so this study is welcomed. The problem, as the authors concede, is that an RCT can only assess one specific hypothesis well.

Their principal finding, as hypothesised, is that 50 sessions of psychotherapy leads to a greater reduction in depression severity and higher remission rates for depression and personality disorder symptoms than 25 sessions of psychotherapy after 1 year.

The result leaves several obvious questions. The first is whether this finding is the result of session frequency, the number of sessions or a combination of both. The second is whether the result would be similar in patients with depression without coexisting personality disorders. The third is what are possible mechanisms that might lead to this superior effect. The fourth is the cost-effectiveness of more intensive treatment and the implications for service delivery.

There is some evidence around the question of session frequency versus the number of sessions. A metaregression by Cuijpers et al[4] reported that there was only a small association between the total number of therapy sessions and effect size, which was no longer significant when adjusted for possible confounders. In contrast, there was a strong association between number of sessions per week and effect size. A recent study by Bruijniks et al[5] also reported that twice- versus once-weekly sessions of cognitive–behavioural therapy (CBT) and interpersonal therapy (IPT) improved depression treatment outcomes, but the total number of sessions was similar in both groups. So it appears that session frequency may be the more important variable.

The second question around patient characteristics is more difficult to discuss because of a lack of evidence. Despite consistent reporting that around half of patients with depression have significant personality pathology, at least in secondary care, there are, to my knowledge, no studies that have examined how treatment should be modified in such patients when treating depression. Many clinicians assume that psychotherapy might better address the issues associated with impaired interpersonal functioning in patients with depression and personality disorders. However, the evidence, such that it is, suggests no difference between the response to psychotherapy and pharmacotherapy in these patients.[3] The study does demonstrate that patients with depression and coexisting personality disorders benefit from treatment but not whether treatment should be modified from standard treatments for depression in such patients. An RCT contrasting specific treatment efficacy in patients with depression with and without a coexisting personality disorder is urgently needed.

The mechanisms leading to the differential response also cannot be directly addressed. The authors speculate that patients with depression and coexisting personality disorders may benefit from more input, but since all patients had personality disorders, we cannot assess this. It is feasible that increased intensity of sessions strengthened learning processes and the therapeutic alliance but these were not measured. Interestingly, the dosage effects only appeared in the second half of therapy so the effects on the therapeutic alliance may be minimal.

Finally, both treatments are longer and more resource intensive than usual psychotherapies for depression. Traditionally, CBT and IPT for depression involves 10–16 sessions. The Bruijniks et al[5] study that examined a similar dosage hypothesis had a maximum of 20 sessions in both groups. However, no studies have deliberately selected patients with depression with coexisting personality disorders. The majority of psychotherapies for patients with personality disorders advocate 50 sessions or more. Nevertheless, in a constrained resource environment, more convincing evidence may be necessary to justify 50 sessions of psychotherapy in patients with depression, regardless of their personality pathology. Would 25 sessions given twice weekly achieve a similar result? Are short-term psychoanalytic supportive psychotherapy and schema therapy less effective with fewer sessions compared with CBT and IPT? A recent meta-analysis examining the effect of coexisting personality disorders on outcomes for CBT in patients with depression reported that any effect was likely explained by higher study intake depression severity than treatment resistance. They noted patients with

https://doi.org/10.1192/bjp.2024.105 Published online by Cambridge University Press

personality disorder showed symptomatic improvements across studies, particularly those with longer treatment durations. However, longer treatment was 16–20 sessions![6]

In conclusion, Kool et al's[2] study is consistent with findings that patients with depression and personality disorders respond to treatment and should not be excluded from treatment trials. It reinforces evidence that structured psychotherapies have similar efficacy.[7] It also adds to the small evidence base suggesting more frequent psychotherapy sessions have superior efficacy. Like all good studies, it generates more questions than it answers, including: does psychotherapy need to be modified in patients with depression and coexisting personality disorders? And are some psychotherapies, such as CBT, more efficient than others in reducing symptoms in patients with depression with or without comorbid personality disorders?

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First received 9 Apr 2024, final revision 21 Apr 2024, accepted 22 Apr 2024

Data availability

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

Funding

This study received no specific grant from any funding agency, commercial or not-for-profit sectors.

Declaration of interest

R.T.M. is an editorial board member of *the British Journal of Psychiatry* but did not take part in the review or decision-making process of this paper.

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https://doi.org/10.1192/bjp.2024.105 Published online by Cambridge University Press