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Psychotherapy of Borderline Personality Disorder

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Abstract

Objective—Psychotherapy is considered the primary treatment for borderline personality disorder (BPD). Currently, there are four comprehensive psychosocial treatments for BPD. Two of these treatments are considered psychodynamic in nature: mentalization-based treatment and transference-focused psychotherapy. The other two are considered to be cognitive-behavioral in nature: dialectical behavioral therapy and schema-focused therapy.

Method—A review of the relevant literature was conducted.

Results—Each of these lengthy and complex psychotherapies significantly reduces the severity of borderline psychopathology or at least some aspects of it, particularly physically self-destructive acts.

Conclusions—Comprehensive, long-term psychotherapy can be a useful form of treatment for those with BPD. However, less intensive and less costly forms of treatment need to be developed.

In addition, psychosocial treatments that are aimed at the quieter but psychosocially detrimental symptoms of BPD are needed.

Borderline personality disorder (BPD) is both a common and serious psychiatric disorder. It affects about 2–6% of American adults (1,2). It is also associated with high levels of psychiatric care (3) as well as high levels of psychosocial impairment (4). In addition, treating borderline patients can be challenging due to their tendency to prematurely terminate psychotherapy (5), regress in treatment (6), and engender strong counter-transference reactions in those attempting to help them (7).

Psychotherapy is considered to be the primary treatment for BPD (8). This is so because of the “stably unstable” nature of BPD (9). The primacy of psychotherapy is also due to the limited efficacy of pharmacotherapy for BPD (10); with most types of psychotropic medication being associated with modest levels of symptom reduction across a number of sectors of borderline psychopathology.

Currently, four comprehensive forms of psychotherapy have been found to be effective in treating those with BPD (11–14). Two of these manualized forms of treatment are viewed as psychodynamic in nature (11,12) and two are viewed as more cognitive behavioral in nature (13,14). The results of these trials and their implications for clinical care and future research are detailed below.

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Psychodynamic Therapies for BPD

Mentalization-based Treatment (MBT)

Bateman and Fonagy developed mentalization-based treatment (MBT) for patients with BPD (11). This treatment aims to increase a patient's curiosity about and skill in identifying his or her feelings and thoughts and those of other people as well. They speculate that this difficulty in mentalization arouse because of difficulties in early attachment.

This manualized treatment was first implemented in a partial hospital setting, which served a relatively poor catchment area of London and which was part of England's National Health Service (15). Thirty-eight borderline patients were randomized to either psychoanalytically oriented individual and group treatment focusing on mentalization principals (N=19) or standard psychiatric care (N=19). Both treatments lasted up to 18 months. It was found that those treated with MBT-informed partial hospital care had significantly better results in the areas of reduced self-mutilatory and suicidal acts, days in hospital, use of psychotropic medications, anxiety and depressive symptoms, and psychosocial functioning.

These same patients were followed-up in two separate reports (16,17). The first detailed the first 18 months after partial hospital treatment or standard psychiatric care (16). The second followed these subjects prospectively for five years after both phases of treatment ended (17).

In the 18^{th} month follow-up, most of those initially treated with MBT-informed partial hospital care were treated with MBT-informed twice weekly group psychotherapy, while those in the standard care group continued to receive treatment as usual (TAU), which typically included medication visits with a psychiatrist and case management visits with a nurse. Those in the partial hospital group had significantly fewer episodes of self-mutilation, made significantly fewer suicide attempts, spent significantly fewer days in the hospital, and were significantly more likely not to be taking psychotropic medications during the 18 months of follow-up. In addition, psychosocial functioning improved significantly more for those in the partial hospital than those in the standard treatment group.

In the five-year follow-up, the partial hospitalization group showed statistical superiority to the control group on suicidality (23% vs. 74%), BPD diagnostic status (13% vs. 87%), service use (2 years vs. 3.5 years of outpatient psychiatric treatment), use of medication (0.02 vs. 1.90 years taking three or more medications), GAF above 60 (45% vs. 10%), and vocational status (3.2 years vs. 1.2 years). Bateman and Fonagy concluded that those in MBT-focused partial hospital care followed by MBT-focused outpatient group psychotherapy did substantially better over time than those in TAU. However, their vocational functioning in particular was less than optimal.

More recently, Bateman and Fonagy (18) have been assessing MBT in an outpatient psychotherapy setting. Preliminary results indicate that this treatment appears to be superior to TAU in some aspects but both structured treatments are useful for those with BPD.

Transference-focused Psychotherapy (TFP)

TFP is based on Kernberg's conceptualization of the core problem of BPD (12). Kernberg suggests that excessive early aggression has led the young child to split his or her positive and negative images of him or herself and his or her mother (19). This excess aggression may have been inborn or it may have been caused by real frustrations. In either case, the preborderline child is unable to merge his or her positive and negative images and attendant affects to achieve a more realistic and ambivalent view of him or herself and others.

The primary goal of TFP is to reduce symptomatology and self-destructive behavior through the modification of representations of self and others as they are enacted in the here and now transference. Clarifications, confrontations, and transference interpretations are the primary techniques of this twice-weekly psychotherapy.

Clarkin et al. (20) have conducted a trial of TFP in outpatients with BPD. Ninety patients with BPD were randomized to one of three year-long outpatient treatments for BPD: TFP (N=31), DBT (N=29), or psychodynamically oriented supportive treatment (N=30). Analyses were only conducted on the 62 patients (69%) who had completed three waves of assessment, indicating continuation into the nine to 12 month period of the trial.

Patients in all three treatments showed significant positive change in depression, anxiety, global functioning, and social functioning during one year of treatment. Both TFP and DBT were each associated with improvement in suicidality. Both TFP and supportive treatment were each associated with improvement in anger and facets of impulsivity. Only TFP was significantly associated with improvement in irritability, verbal assault, and direct assault. While TFP was significantly associated with more outcome measures, there were no significant between-group differences. However in a separate report, it was found that TFP was associated with significantly greater improvement than comparison treatments in two psychodynamically important areas: more secure attachment and greater reflective capacity (21).

Cognitive Behavioral Therapies for BPD

Dialectical Behavioral Therapy (DBT)

Linehan (13) has suggested that the core feature of BPD is emotional dysregulation. She suggests that this lability may be due to both inborn biological vulnerabilities and an invalidating childhood environment. In any case, the person with BPD is easily upset, becomes extremely upset very rapidly, and takes a good deal of time to calm down. Linehan also suggests that emotional dysregulation then fuels both the impulsivity and interpersonal turbulence that is characteristic of those with BPD.

Linehan first published results of a randomized trial of DBT in 1991 (22). This treatment consists of skills groups, individual therapy as well as phone coaching for patients, and a consultation team for clinicians treating them. She found that DBT was superior to TAU, both of which lasted for a year, in reducing the number of episodes of parasuicidal behavior (self-mutilation and suicide attempts) and their medical severity. Those treated with DBT were also significantly more likely to stay in individual therapy and had significantly fewer days in the hospital for psychiatric reasons.

In a second study, these subjects were followed for another year (23). It was found that during the first six months of the follow-up, those treated with DBT had significantly less parasuicidal behavior, less anger, and better self-reported social adjustment. During the second six months of follow-up, those treated with DBT had significantly fewer psychiatric inpatient days and better interviewer-rated social adjustment. The authors conclude that DBT retains its superiority to TAU over a one-year follow-up period.

Linehan has also conducted a randomized trial of DBT vs. community treatment by experts (CTBE) (24). The trial consisted of one-year of DBT and one year of follow-up. Subjects being treated with DBT were half as likely to make a suicide attempt, required less hospitalization for suicide ideation, and had lower medical risk for all suicide and self-mutilatory acts together. Subjects treated with DBT were also less likely to drop out of treatment, had fewer psychiatric hospitalizations, and had fewer emergency room visits. The

authors conclude that the results of this study suggest that DBT's effectiveness is not due solely to general factors associated with expert treatment.

Verheul and his colleagues have also conducted a study of the efficacy of DBT (25). He compared DBT to treatment as usual in Holland. DBT resulted in a significantly better retention rate and significantly greater reductions of self-mutilating and self-damaging impulsive behaviors, particularly among those with a history of frequent self-mutilation. Taken together, the results of this study suggest that clinicians independent of Linehan's Seattle group can successfully provide DBT.

Schema-focused Therapy (SFT)

SFT is based on the work of Jeffrey Young (14). Borderline patients are thought to have four dysfunctional life schemas that maintain their psychopathology and dysfunction: detached protector, punitive parent, abandoned/abused child, and angry/impulsive child. Change is achieved through a range of behavioral, cognitive, and experiential techniques that focus on the therapeutic relationship, daily life outside therapy, and past experiences (including traumatic experiences). Recovery in SFT is achieved when dysfunctional schemas no longer control the patient's life.

SFT was compared to TFP at four community mental health centers in Holland (26). Each therapy was conducted for up to three years and each involved two sessions per week. Forty-five patients were randomized to SFT and 43 to TFP. Thirty-three completed SFT and 27 were still in treatment. In contrast, 21 completed TFP and 19 were still in treatment.

Statistically and clinically significant improvements were found in both treatment groups on all four study outcomes. These outcomes were: borderline psychopathology, general psychopathology, quality of life, and SFT/TFP personality concepts. Those treated with SFT also were found to have done significantly better than those treated with TFP on each of these outcomes. In addition, they were found to have significantly greater reduction in symptom severity on six of the nine DSM-IV criteria for BPD (each of the symptoms of a cognitive, impulsive, and interpersonal nature): identity disturbance, dissociation/paranoia, physically self-destructive acts, other impulsivity, abandonment fears, and stormy relationships. However, no significant between-group differences were found on any of the three DSM-IV affective criteria for BPD: anger, emptiness, or moodiness. In addition, SFT was associated with a significantly higher retention rate.

Discussion

Taken together, the results of these studies indicate that there are now four manualized psychosocial treatments for BPD that have proven to be somewhat effective in decreasing borderline psychopathology or at least, selected aspects of it. These symptomatic improvements have been most consistent in the areas of self-mutilation and suicide attempts. This treatment focus makes a good deal of sense as these acts are among the most common reasons for costly psychiatric hospitalizations. They are also a leading indicator of a deteriorating clinical state that can lead to broken relationships and a substantial decrement in psychosocial functioning.

It is a real advance in the field that both clinicians and patients now have four treatments from which to choose. This is important as one treatment approach may make more sense to a particular clinician or a particular patient than the others.

In addition, the evidence is not particularly strong that one treatment is better than another. It is definitely true that DBT is the most thoroughly studied of these treatments and the one

most widely used, particularly in the US. But it is not clear that it is better than these other treatments. Rather, it seems that borderline patients are quite responsive to a variety of treatments. The take home message may be that any reasonable treatment provided by reasonable people in a reasonable manner may be beneficial to these patients.

Despite the advance that these treatments represent, there remains much to be done. It is clear that all of these treatments are both intensive and relatively long in duration. These also require special training. For these reasons, they may be beyond the ability of most private practitioners, mental health clinics, and even major medical centers to provide. Less intensive and less costly forms of psychosocial treatment for BPD are needed. In order to treat more borderline patients with a proven manualized psychotherapy for BPD, it may be necessary to rely on adjunctive forms of treatment. One such treatment with proven efficacy is STEPPS—a group treatment lasting 20 weeks (27).

It is also clear that only SFT has proven efficacy with a broad range of BPD symptoms. This may be because of it was the only study to measure the severity of symptoms from all four sectors of borderline psychopathology and this, in turn, may have been due to the fact that the other treatment developers did not have access to such a measure. However, it is clear that both DBT and MBT are primarily aimed at reducing the frequency of physically self-destructive acts and their sequelae.

However, recent research has shown that about half of the symptoms of BPD are acute in nature and half are temperamental in nature (28). According to this research, acute symptoms resolve relatively rapidly, are specific to BPD, and are often the reason for costly forms of treatment, such as psychiatric hospitalizations. In contrast, temperamental symptoms are relatively slow to resolve, are not specific to BPD, and are associated with ongoing psychosocial impairment. Self-mutilation and help-seeking suicide attempts are examples of acute symptoms, while intense anger and profound fears of abandonment are examples of temperamental symptoms.

A fully successful comprehensive treatment for BPD must address both acute and temperamental symptoms. It may be that these comprehensive treatments will need to be revamped to address both types of symptoms. Or they might be followed by other treatments aimed to these more long-lasting symptoms that have such a negative impact on both social and vocational functioning.

Going forward, treatment researchers need to establish a standardized set of outcomes for BPD and a standardized set of measures to assess these outcomes. With out this, it will remain extremely difficult to assess the relative efficacy of these treatments.

In conclusion, comprehensive, long-term psychotherapy can be a useful form of treatment for those with BPD. However, less intensive and less costly forms of treatment need to be developed. In addition, psychosocial treatments that are aimed at the quieter but psychosocially detrimental symptoms of BPD are needed.

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Clinical recommendations

- Comprehensive psychosocial treatments for BPD have proven to be effective
- However, their training requirements and cost make their widespread use problematic

Additional comments

- Treatments that deal with a wider range of borderline symptoms, including those most associated with psychosocial impairment, are needed
- Such treatments may be adaptations of currently available comprehensive treatments or newer treatments developed specifically for this purpose