

Treatment Approaches for Borderline Personality Disorder

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This paper review the literature on the treatment of BPD and concludes with a summary of the areas of consensus between the evaluated approaches. It includes literature published before mid 2003 and primarily considers treatment from the perspective of DHB services.

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Introduction

Treatments for BPD clients do not lend themselves to easy evaluation due to pervasive longstanding problems, complex co-morbidities and high treatment dropout rates. However since the early 1990s there has been a strong interest in BPD across psychiatry, psychotherapy and clinical psychology. There is now a growing body of empirical literature to guide treatment selection and service development for BPD adults. Unfortunately the literature has few randomised-controlled trials or other such studies. Treatment decisions must still be guided by a weaker scientific basis than found in other domains of psychiatry/psychology. The APA (2001) advise caution in reading the literature due to uncertainty generated by:

1. the heterogeneous presentations, range of clinical severity and frequent co-morbidities of clients within the BPD diagnostic criteria;
2. variable research criteria for including or excluding clients;
3. questions concerning the applicability of findings from specialised research facilities to general treatment services. This point may be particularly pertinent when attempting to apply a psychotherapeutically based approach across a DHB treatment system;
4. the multi-component nature of most treatment, in which “active” treatment elements have not been identified;
5. the lack of control of adjunctive medications in many psychotherapy evaluations; and
6. the lack of literature specifically regarding adolescents, although findings from adult studies *may* generalise to younger age groups (at least in principle, if not practice).

Authoritative Reviews

It is beyond the scope of this paper to extensively review the extensive literature on the treatment of BPD. However we have summarised some recent literature reviews and current treatment approaches. Interested readers are encouraged to follow up the cited references and more current studies.

The Cochrane Collaboration (for evidence based health-care) has not reviewed the treatment of BPD. Regarding deliberate self-harm, it states there is insignificant evidence to make firm conclusions but notes significant benefits from Dialectical Behaviour Therapy (DBT) and flupenthixol as well as non-significant benefits from problem-solving therapy and an emergency contact protocol (Hawton et al, 1998).

In recent meta-analyses Bateman and Fonagy (2000) and Leichsenring and Leibing (2003) have both reviewed a number of reports (25 and 22 respectively) of the psychotherapeutic treatment of all personality disorders, including BPD. Selected studies varied by diagnostic grouping, treatment approach, setting, duration and design. Both reports concluded positive effects from a range of psychotherapies but they were unable to determine if any particular approach was superior to another. Unfortunately a minority of the studies contained BPD-only groups and even fewer employed randomised-controlled trials.

In its Treatment Guidelines for BPD (2001) the American Psychiatric Association concludes that the primary treatment of BPD is psychotherapy complimented by symptom-targeted pharmacotherapy. The guidelines state that at the time of writing it had not been established that any one form of psychotherapy was superior to others.

Unfortunately these guidelines have not answered all the questions nor resolved the many debates. They have been received as:

- Important in finally recognising BPD to be in the same category of clinical importance as other major psychiatric conditions (Paris, 2002);
- Limited by research base and with a limited consideration of psychoanalytic and psychodynamic treatments (McGlashan, 2002);
- Weak, misleading or inaccurate while favouring psychoanalytically informed psychotherapies over cognitive-behavioural therapies. (Sanderson, Swenson and Bohus, 2002);
- Not necessarily representing advancement in the understanding of this disorder (Tyrer, 2002).

Also note that these guidelines reflect the American cultural values, healthcare models and legal environments, which are significantly different from New Zealand. They may not generalise easily to the New Zealand DHB environment when considering important issues such as cultural responsiveness and risk management.

Evaluated Literature

In the literature, treatments are often described as either “psychodynamic” or “cognitive-behavioural” despite the considerable differences of both theory and process within either grouping, and despite the blurring of these approaches evident within more contemporary and integrative approaches. As such we describe some main themes within those groupings and pay particular attention to approaches supported by:

- A strong clinical literature;
- A trained or interested health workforce within New Zealand;
- Rigorous evaluations such as randomised-controlled trials (RCT), widely regarded as the "gold standard" in evaluation. However in complex treatments RCT can have limitations and have been described as sometimes unnecessary, inappropriate, impossible, or inadequate (Black, 1996, also Wells, 1999). Careful observational (cohort and case control studies) designs can help provide a fuller picture and some have been included here.

We focus on approaches used with BPD clients at the more severe end of the condition, reflecting those most likely to be found within DHB services.

Cognitive Behavioural Studies

CBT conceptualisations typically accept the DSM IV description of BPD and then formulate a theoretical definition of BPD within their own terms. For instance Linehan (1993) states that BPD is primarily a “pervasive dysfunction of the emotion regulation system”. Beck and Freeman (1990) describe three core cognitive schema present in BPD as “The world is dangerous and malevolent”, “I am powerless and vulnerable” and “I am inherently unacceptable”.

The empiricism and evaluation that has become almost synonymous with CBT in treating Axis I conditions has not yet been extended to CBT approaches with Axis II conditions. To date (August 2003), most CBT approaches have been limited to theoretical descriptions (e.g, Beck, 1990) and/or case reports or pilot studies (e.g, Laydon et al, 1993). In fact, excluding DBT, the number of CBT citations regarding BPD treatments may have decreased over the past decade.

More complex cognitive therapy approaches tend to:

- Develop the standard cognitive conceptualisations to include developmental issues;
- Be schema-centred psychotherapies based on information-processing models (Cottraux and Blackburn, 2001);
- Place more emphasis on developing effective collaborative relationships, some including active techniques for conceptualising and working within the therapeutic relationship;
- Apply/adapt standard cognitive therapy methods;
- Apply methods derived, adapted or translated from other therapeutic literature, e.g. the use in schema therapy (Young *et al*, 2003) of imaginal role-play and object-relations concepts.

Randomised-Controlled Trials

DBT

To date, the treatment approach with the greatest number of randomised controlled trials in the treatment of BPD is Dialectical Behaviour Therapy (DBT, Swenson, Torrey & Koerner, 2002). DBT (Linehan, 1993a) is an eclectic, principle driven therapy including some psychoanalytic and eastern spiritual ideas within a cognitive-behavioural therapy framework and a dialectical philosophy. It has been considered by some as an integrative therapy (Heard, 2002). In essence BPD is seen as dialectical failure – the inability to hold or synthesise the tensions that exist in life. BPD is seen as arising from an innate emotional vulnerability combined with a chronically invalidating developmental environment. DBT reformulates BPD into functional targets of mindfulness, distress tolerance, emotion regulation and interpersonal effectiveness. Treatment (change) is only possible within the acceptance of what is. Treatment lasts for at least a year, is based around an individual therapist, is overseen by a consultation team and employs cognitive-behavioural skills training in groups.

In a series of reports on a randomised controlled trial, Linehan and her group (Linehan, et al, 1991; Linehan, et al, 1994) compared DBT with treatment as usual (TAU) for chronically parasuicidal women. They showed DBT to yield reduced rates of self-harm, reduced severity of self-harm, dramatically reduced hospital usage, lower anger and increased social functioning. Linehan et al (1999) also report a randomised controlled trial of modified DBT in the treatment of BPD women with substance use disorders. The BPD group had lower dropout rates and, at four months follow-up, less drug use.

Verheul *et al* (2003) reported similar positive findings from a randomised trial comparing six months of DBT with TAU for BPD women with less severe

presentations than that in the Linehan studies. The TAU was by cognitive behavioural therapists.

Compared with waitlist controls, modified DBT has been reported as effective in randomised trials with bulimic women (Safer, Telch and Agras, 2001). Turner (2000) reported a randomised controlled comparison of modified DBT (incorporating psychodynamic case conceptualisation) with a client centred approach for treating a diverse range of men and women in a community mental health clinic. The DBT group showed lower dropout and greater improvements in suicidality, self harm, hospital use, anger, depression, and impulsiveness.

There is also a range of literature reports with cohort and uncontrolled designs suggesting DBT's effectiveness with a range of clinical populations and settings including forensic BPD women, forensic settings (McCann, *et al*, 2000), residential settings (Wolpow *et al*, 2000), family therapy with youth (Miller *et al*, 2002; Hoffman *et al* 1999), bulimic women, abusive men (Waltz, 2003), substance abusers (Dimeff *et. al*, 2000), depressed older adults (Lynch, *et al*, 2002). These newer applications tend to focus on patients with personality disorders for whom emotion dysregulation appears functionally related to their presenting problems. New behavioral targets are specified to address the differing presenting problems (Linehan, 2000). By themselves, DBT groups (without individual therapy and consultation supports) do not work. Adding DBT groups to non-DBT therapy has not been beneficial (Linehan, Heard and Armstrong, unpublished study cited in Linehan 1993). DBT groups alone were also found ineffective (compared to full DBT) in an inpatient DBT study (Barley *et al*. 1993).

Two cost-benefit analyses have reported DBT as saving 50% (Linehan & Heard, 1999) and 58% (The APA Achievement Awards, 1998) of TAU costs. Overall savings resulted from greatly decreased inpatient use combined with significantly increased outpatient costs. DBT has also been found to reduce therapist' s burnout (uncontrolled trial: Little, 2000) and to be comprehensible to general mental-health staff (Hawkins & Sinha, 1998). DBT may also lend itself well to structuring a treatment system. There are reports on the successful adoption of DBT within existing mental health services (e.g. The APA Achievement Awards, 1998) and literature on the likely barriers and solutions to implementing DBT programmes (Swenson, Torrey and Koerner, 2002).

Manual Assisted Cognitive Therapy

MACT uses bibliotherapy (booklets or clients manuals) to implement or support a cognitive therapy. Responding to the resource intensive nature of DBT, Evans *et al* (1999) compared MACT (six sessions, n=18) with treatment as usual (n=16) for clients with recurrent deliberate self-harm (cluster B diagnosis). The manuals contained elements of DBT. At follow-up (6 months?) the MACT group showed significant improvement in self-rated depressive symptoms and a non-significant reduction in self-harm.

Following on from that report, Tyrer *et al* (2003) have reported on the multi-centre POPMACT randomised controlled trial of brief manual assisted cognitive therapy (MACT) compared with treatment as usual (TAU) for recurrent deliberate self-harm

(n=480), 42% of whom had a diagnosis of a personality disorder. The MACT consisted of a 70-page manual with up to seven CT sessions within a three month period. Follow-up at one year showed no significant difference between groups other than MACT being cheaper than TAU (Byford *et al*, 2003).

At this stage MACT cannot be recommended an effective treatment for deliberate self-harm or BPD.

Other Noteworthy Cognitive-Behavioural Approaches

Schema Therapy

Jeffrey Young's (Young *et al.*, 2003) Schema Therapy (ST) is mentioned as it has been of considerable interest to many psychologists looking to work effectively with clients with more complex presentations, including BPD. ST provides a blend of cognitive therapy, object relations and gestalt techniques into an active treatment of core schema. BPD clients (and other more challenging clients) are treated within a "mode" form of the therapy, initially targeting intrapersonal/interpersonal states that impede the normal flow and collaboration of therapy. ST would usually *follow* the treatment of an Axis I condition or, with BPD, where the client has a level of safety and stability. Young therefore recommends that BPD clients may require more DBT-oriented interventions as the first stage of therapy before ST.

ST has being trailed on some BPD clients with severe distress but evaluations of ST have yet to be published. Currently the recommendation for initial safety and stabilisation treatment suggests that ST should only be considered later within a treatment pathway, possibly as a "Stage 2", emotional experiencing or schema-level therapy.

Psychodynamic Studies

While not intended as a review, some of the main psychodynamic theories and authors are very briefly summarised prior to considering the evidence of effectiveness.

Psychodynamic and psychoanalytic psychotherapies share the assumptions that BPD is a developmental disorder involving a disturbance of self that encompasses both ego functions and object relations. Traditional psychodynamic treatments emphasise a restorative holding and nurturing therapeutic relationship, allowing regression and transference within a relationship where the therapist's adult faculties are intact. Various psychodynamic approaches differ significantly in terms of theory and process.

Masterson (1981) conceptualised BPD as a disorder of self, arising from failure of separation-individuation. From her own unfulfilled needs, the mother is unable to tolerate the child's natural separation-individuation. The child's growth and individuation yields a loss of maternal support, resulting in depression. This conflict is managed by splitting of the mother, and the self, into "all-good"/"all bad" objects and at the cost of a fragmented internal world. Masterson's therapeutic approach is to consistently confront the unhelpful splitting defences, while targeting the

“withdrawing object relations unit”, the “regressing object relations unit” and idealising defences.

Kernberg (1984) developed ego psychology and object-relations theories to consider the BPD person to have un-integrated self-object representations along with a constitutional excess of aggression. The BPD person manages their destructive fantasies by dis-integrating thoughts, feelings and actions. This is at the expense of a cohesive identity. Kernberg’s therapy is confronting of transference distortions and perceptual/cognitive errors. Therapy is well bounded with a clear treatment contract, consistent limits and targeting of behaviours that impede therapy, such as lying and manipulative self-mutilation.

Clarkin et al (1999, cited in Bateman and Fonagy, 2000) have reported preliminary data from a controlled study with 10 BPD clients using a transference-focused psychotherapy developed with Kernberg. The preliminary data has reported significant improvements for patients without antisocial features but substantial data has yet to be reported.

Kohut’s (1971) self psychology was initially a “non-drive” modern psychoanalytic therapy for narcissistic disorders. It saw BPD as a developmental arrest resulting from the empathic failure of others (mother). This results in frustration, the failure to develop holding/soothing introjects and prevents the development of the nuclear-self to the cohesive self. Treatment requires vicarious introspection and empathy as methods for exploring the subjective experience of the clients. The therapist provides a holding tolerant atmosphere, remaining available when working to resolving negative self-object transferences.

Randomised Controlled Trials

In a randomised controlled trial Bateman and Fonagy (1999) found that compared to a TAU group, BPD patients assigned to a psychoanalytically informed day hospital had substantially less self-harm, parasuicidal behaviour, hospitalisation and psychiatric symptoms. The treatment involved psychoanalytic psychotherapy (individual weekly and group 3 times per week), psychodrama, community meetings and medication. TAU was community based under general psychiatric care with similar medication. At 18 month follow-up (Bateman and Fonagy, 2001) the treatment group generally showed a maintenance of treatment gains and continued improvement on most measures.

Other Noteworthy Psychodynamic Evaluations

Self Psychology

Stevenson and Meares (1992; Meares et al 1999) have reported on a psychodynamic therapy developed from Kohut’s self-psychology and Winnicott’s object-relations theory. Their methods include a clear treatment structure, targeting of troublesome behaviours (e.g. impulsivity) and strong efforts to enhance compliance.

Initially in a prospective design (comparing 30 clients before and after treatment, without controls) the authors reported reduced self-harm, improved occupational functioning, approximately halved hospital admissions and bed-days, dramatically

reduced visits to medical practitioners and reduced score on symptom checklists. After 12 months of twice-weekly psychotherapy 30% of the treatment group no longer met criteria for BPD. Many improvements were maintained at 5 years with considerable savings in health care costs due to decreased hospitalisation (Stevenson and Meares, 1999). The authors then compared this treatment group with a *non-randomised* control receiving uncontrolled TAU (supportive therapy, cognitive therapy and crisis intervention) and found their treatment group had significantly better outcome (Meares and Stevenson, 1999). However findings are compromised by weak design including the non-randomisation and un-blind assessment.

Integrative and Other Approaches

Cognitive Analytic Therapy

Ryle's (1990, 1997) Cognitive Analytic Therapy is an integrative blend of Personal Construct Theory (Kelly, 1955) with a cognitive re-conceptualisation of some elements of object relations theory. CAT was developed as a general brief structured treatment for UK national health settings before being developed specifically for BPD clients (Ryle, 1997).

CAT regards personality structures and the self as being developed through the internalisation of early relationships with significant others. Internalized dialogues from the past are expressed in and maintained (or modified) by current relationships. (Ryle & Kerr, 2002). For BPD clients CAT emphasizes harsh reciprocal role patterns, impoverished capacity for self-reflection and the propensity for partial dissociation. (Ryle and Kerr, 2002).

Using collaborative cognitive practices as well as an awareness of transference and countertransference, clients discover the consequences of their ineffective and unfulfilling modes of relating to people. They generate diagrammatic reformulations (including flow diagrams) of the complex processes of their core self (Ryle & Kerr 2002). Links are made between the intended aims of the communication and the actual outcome. This self-reflection aims to increase integration and assist in the recognition and revision of these destructive role procedures. Emotional needs are more effectively met and previously ineffective relationship patterns are discarded.

So far clinical reports have been limited to pilot studies and case studies (e.g. Wildgoose, et al, 2001; Kerr, 1999). Ryle and Golyunkina (2000) found some benefits in an uncontrolled study with time-limited CAT with 39 BPD clients. Currently there are randomised controlled trials of CAT currently for BPD and a range of other conditions at a variety of centres: see www.acat.org.uk for details.

Assertive Case Management

Community mental health team management (CMHT, Tyrer et al 1997) and assertive case management (ACM, Marshall *et al.* 1996) are popular care approaches in New Zealand DHBS. Both have been reviewed by the Cochrane Library (for evidence based healthcare) and found effective in maintaining contact with patients with serious mental disorders (mostly psychotic diagnoses). For those groups, CMHTs may reduce hospitalisation and reduce suicide rates. ACM may approximately double

hospitalisation rates but with little evidence of improved mental state, social functioning or quality of life.

There are no solid conclusions on the benefits of these approaches for BPD. In Canada, Links (1998) reviewed ACM for personality disorder diagnoses (including BPD) and noted reduced suicide attempts and less reliance on inpatient admissions due to maintaining contact, increasing client satisfaction and ensuring compliance with treatments. In Australia / New Zealand and for BPD clients, *standard* reactive case management approaches have been associated with the reinforcement of self-harming behaviour (Krawitz and Watson, 2000) and possible iatrogenic harm.

The specific care issues of the BPD client must be considered within their case management (Davison, 2002). BPD clients may generally benefit from CMHTs featuring lower levels of case-management (which do not encourage hospitalization) and holding an adherence to clear boundaries, clear treatment goals, clear limits on what is acceptable behaviour and the active management of team splitting (Oxfordshire NHS Medical Advisory Group, 1998.).

Relationship Management/ “No-therapy therapy”

Dawson and MacMillan’s (1993) ‘No-therapy therapy’ is a relationship management approach. It is mentioned here due to having some popularity in Australia, despite an absence of evaluation. Clinicians emphasise the interactional nature of behaviour and focus on the process (not content) of communications. The clinician tries to be a warm active listener while expressing their inability to know how else to help and not taking responsibility for the client’s behaviour. It is unclear if such an approach would work currently within New Zealand where clinicians are widely expected to know what to do. Also there are literature-based approaches (above) that specify what clinicians should be able to do.

Medication

The mainstay of BPD treatment is appropriate psychotherapy (APA, 2001) enacted in an integrated way across the treatment service. Medication may play an important adjunctive role in symptom management. The APA has published treatment algorithms that extrapolate the limited empirical literature into suggested strategies for treating affective instability, impulsivity and psychotic-like states (see APA, 2001 – also available on the internet). Medication may also have a role in the management of comorbid Axis I conditions.

There are particular challenges using medication to treat BPD clients:

- Medication is often overused. It is not best practice to consider medication as the primary treatment strategy for BPD;
- Prescribing should be within an integrated team approach and not enacted outside of the main treatment plan;
- There needs to be a clear rationale for the use of all medications, especially sedation. The APA (2001) notes that despite the widespread use of benzodiazepines there is little evidence of effectiveness. Some case-studies report benefit while other studies have shown increased impulsivity and suicidality;

- BPD clients often misuse medication, especially those with abuse potential;
- BPD clients often stockpile prescribed medication and take this in overdose. There is evidence that those with prescribed psychiatric medication are more likely to take the prescribed medication (rather than over-the-counter medicines) when taking overdoses (Lo *et al*, 2003);
- Medicines with low toxicity should be preferred;
- Medicines should not be dispensed in dangerous quantities. Nor should dispensing be on an inconvenient or punitive schedule (e.g., daily) unless there is a clear rationale for this;
- Reviews of prescription overdoses should be considered within the dynamics of the prescribing relationship;
- If medication does not produce the required benefits it should be stopped;
- Frequent changes to medication and reactive changes in crisis can undermine psychological treatments and externalise responsibility for recovery;
- The BPD client is ultimately responsible for the taking the prescribed medication. Like all client groups they should receive adequate education about the effects of medications. Struggles over compliance should be considered within the dynamics of the prescribing relationship.

Areas of Consensus

The APA treatment guidelines provide an eloquently simple summary: the primary treatment of BPD is some kind of psychotherapy supported by symptom-focused pharmacotherapy.

As yet there is no definitive answer as to which kind of psychotherapy is most effective and it may be that different types of psychotherapy are better for different profiles of BPD clients. Currently DBT, Bateman & Fonagy's psychoanalytically oriented partial hospitalisation and Stevenson & Meares' self-psychology are the best-researched treatment models for BPD clients. Currently DBT slightly leads the race in published evaluations. Over the next few years a much clearer picture is likely to emerge.

The ideological schisms and sectarian arguments between factions of the psychotherapy community tend to detract from the potential *rapprochement* of theory and practice occurring between the psychoanalytic and cognitive therapies for personality disorders (Bateman, 2000). These conflicts also waste effort and undermine service delivery to clients. However this does *not* mean that all psychotherapies are of equal value: poorly considered or ill structured psychotherapies may be harmful to this, and other, client groups.

There are many common themes within the evaluated literature. From their review of the treatment of all personality disorders (including BPD), Bateman and Fonagy (2000) concluded that treatments shown to be moderately effective shared a number of features. They are:

- Well structured
- Make considerable efforts to enhance compliance
- Have clear focus, whether the targets are behavioural or interpersonal
- Are theoretically coherent to both therapist and client

- Are relatively long-term. The APA (2001) notes that most BPD clients “will need extended psychotherapy in order to attain and maintain extended improvement in their personality, interpersonal problems and overall functioning” (APA, 2001, A.I.3.a).
- Encourage a powerful attachment relationship between therapist and client, enabling the therapist to adopt an active (rather than passive) stance;
- Are well integrated with other services available to the client.

Other similarities within the evaluated BPD literature include:

- Reducing blame or criticism of clients;
- Treating clients as capable (not fragile)
- Emphasising hope and recovery;
- Providing a framework for coping with risk.

Many of these treatments also propose a sequence of recovery stages, varying targets and process according to the *current* presenting problems and client’s stage of recovery (e.g, targeting suicidality, when present, as the primary goal). Sometimes obvious and sometimes overlooked, the treatment should be selected/adjusted to match the client’s needs rather than the client be expected to benefit from whatever form of therapy is offered.

The task of effective DHB treatment is to translate this treatment frame across DHB services.

References

Please see the related document “BPD References”