Psychotherapy for borderline personality disorder

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Abstract

Objective: This paper aims to provide a succinct overview of the factors common to empirically validated psychotherapies for borderline personality disorder (BPD), including the treatment structure required.

Conclusion: Individual psychotherapy remains the cornerstone of treatment for BPD. Factors common to empirically validated modalities of therapeutic treatment have been identified. These need to be provided within an individualised and structured treatment framework. Improved outcome of treatment for BPD can then be achieved.

Keywords: psychotherapy, borderline personality disorder, effective treatments

Introduction

Knowledge about effective psychotherapies for borderline personality disorder (BPD) has grown steadily since the 1990s. Several modalities of psychotherapy have now been empirically validated for BPD in carefully conducted randomised controlled trials (RCTs).[1,2]

Individual psychotherapy has long been regarded as the principal form of treatment for BPD.[3,4] The availability of resources in Australia is such that most patients with the illness are likely to be treated in general psychiatric services rather than in specialist services for personality disorder, yet psychotherapy for BPD is not readily available in public general psychiatric systems. Recent findings regarding the positive outcome of structured psychotherapeutic approaches to treatment in general psychiatric systems[5] offer hope that this could change.

This paper will outline the ingredients for effective psychotherapeutic treatment of BPD.

From therapeutic nihilism to hope

Patients with BPD were considered 'unanalysable,' and therapeutic nihilism prevailed with regard to their treatment until the 1990s. This attitude began to change with the publication of two important studies. Linehan et al. in 1991 published a study showing the effectiveness of cognitive-behaviour therapy (CBT) in the treatment of chronically parasuicidal borderline patients.[6] Stevenson and Meares published their outcome study of treatment for BPD according to the 'Conversational model' in 1992.[7] Each of these studies, using different psychotherapeutic methods, affirmed that BPD could be effectively treated and that symptoms which cause great anxiety to clinicians, including suicidal and parasuicidal behaviours, can improve with psychotherapeutic treatment.

Further positive findings from outcome studies followed. Seven psychotherapeutic treatments for BPD have now achieved empirical support via RCTs in adults.[1–3] (see Box 1) Acceptance and commitment therapy (ACT) was shown to be effective in a pilot RCT conducted at Spectrum published in 2012.[8] This study needs replication with a larger cohort of patients and controls. Nevertheless, the findings were promising for the effectiveness of ACT in BPD.

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Box 1. Empirically validated treatments for borderline personality disorder (BPD) in adults

Dialectical behaviour therapy (DBT)
Mentalisation-based treatment (MBT)
Transference-focused therapy (TFP)
Schema-focused therapy (SFT)
Cognitive-behaviour therapy (CBT)
General psychiatric management (GPM)
Systems training for emotional predictability and problem solving (STEPPS)

Recent RCTs compared the effectiveness of several of these treatments with other empirically validated treatment or treatments.[1,2] None stood out as more effective than the others, although DBT may offer some advantage with suicidal and self-harming patients.[2,9] Determining what the treatments had in common was the next step towards identifying the necessary and sufficient ingredients of change for BPD.

Common factors in empirically supported psychotherapies for BPD

It is now apparent that the similarities between empirically supported treatments for BPD outweigh any differences.[1,2,5,10,11]

The factors common to the empirically supported psychotherapies for BPD are listed in Box 2. This list has been derived from three sources: studies employing rating scales to assess interventions across empirically supported treatments,[1,2] a comprehensive examination of RCTs involving specific forms of psychotherapy and of so-called generalist treatments for BPD,[5] and expert opinion.[3,4,10,11]

The main factors will be discussed in turn.

- **Clear, structured, treatment framework** refers to appointment times, fees and cancellation policy in private practice settings, arrangements regarding holidays, agreement regarding telephone calls, confidentiality and accepted and prohibited behaviours.[1] A clear treatment framework also involves theoretical coherence and a clear rationale for the treatment, communicated to the patient via collaborative discussion prior to treatment commencement. Integration and communication with other clinicians or services involved with the treatment are essential to the provision of a 'holding' environment. Experience suggests that this integration can best be achieved via an overall treatment plan, delineating the roles of every clinician or service involved, and ensuring a process of communication between them.

Box 2. Common factors in empirically supported treatments for borderline personality disorder (BPD)

- Clear, structured treatment framework
- Focus on the relationship with the therapist
- Active therapist
- Collaborative, cooperative relationship with the therapist
- Focus on affect
- Exploratory interventions
- Change-oriented interventions
- Support/supervision for the therapist
- Individual sessions are usually conducted once weekly for minimum of 12 months

- **Focus on the relationship with the therapist** involves close attention to this relationship. It is preferable that therapists choose to work with people with BPD and remain hopeful, interested and engaged throughout the course of treatment. Validation of distress and genuinely empathic responses are essential to positive engagement and outcome. An individualised approach, according to the treatment needs of the patient at different points in time, is crucial. Consensus on the goals of the treatment, with collaborative agreement on how to achieve the goals, is also important.
- Thoughts, feelings and behaviours toward the therapist are a focus of therapy. The patient's relational patterns can be identified in the interaction with the therapist and fully explored there. Repair of misunderstandings/disjunctions is critical to progress and sometimes to continuation of the therapy. Therapists are more self-disclosing with patients with BPD than in traditional forms of therapy in the interest of promoting engagement with the patient as a 'real' person. Attention to the therapist's countertransference is essential, given that intense feelings in therapists can disrupt, if not derail, the therapy.
- **Active therapist**. Therapists are encouraged to be fully mentally and emotionally engaged with their patients. Active engagement is conveyed via active exploration, for example, of the meaning of an event inside or outside the therapy. A piece of behaviour, a silence, an abrupt change in the patient's affect in the room, or what the patient might be thinking or feeling about a current or recent event are possible examples. There is no place for a silent therapist with BPD, where silence can be experienced in terms of rejection or abandonment.

- **Collaborative, cooperative relationship with the therapist.** All of the empirically validated treatments for BPD endeavour to establish a collaborative, cooperative relationship with the patient prior to commencing therapy. Most allow time to provide psycho-education about BPD before commencing treatment. Psycho-education can, in itself, be therapeutic. Ensuring that the patient understands the therapy modality and rationale is important for maintaining a therapeutic alliance during treatment.
- **Focus on affect** refers to close attention to the emotional experience of the patient, identifying shifts in affect during sessions and exploring these with the patient. Patients are encouraged to name and describe what they are feeling. The therapist models the ability to bear intense emotions and encourages the patient's increasing ability to do so.
- **Exploratory interventions** involve exploration and clarification of what has led up to maladaptive behaviours, distressing emotional experiences, etc. These are methodical endeavours to encourage the patient to retrace what has occurred in order to understand the feelings, thoughts, attitudes, and possible repetition of behavioural patterns that have led up to and followed the event in question. This is performed collaboratively, although judicious confrontation may be required at times. The underlying aim is to encourage reflection on the mind of self and of others.
- **Change-oriented interventions**. Change is promoted in different ways by each of these therapies. Development of the capacity to reflect on minds is arguably the most important ingredient for psychic and behavioural change in BPD. Other interventions to promote change include direct challenge of self-defeating thoughts, limit-setting, and in DBT, skills-training and homework.
- **Support/supervision for the therapist**. TFP, GPM, DBT and MBT all advocate the availability of support and/or supervision for therapists. Most clinicians who work with BPD regard the availability of supervision for therapists as essential. The counter-transferences with these patients are often intense and therapists of all persuasions can become entangled in projective identifications. Assistance from a supervisor to get out of such entanglements can help to avoid counter-therapeutic enactments on the therapist's part.[12] It is important to note an error in the paper by Weinberg et al.,[1] in which Table 1 incorrectly lists TFP as not advocating therapist support or supervision.
- **Frequency of individual therapy sessions.** Most empirically validated treatments for BPD advocate individual therapy sessions weekly for at least one year. In some cases group therapy is added to the individual treatment (MBT, DBT). TFP conducts at least twice weekly individual sessions and does not include group treatment, while STEPPS is an educative group treatment approach.[1]

Differences between the empirically validated psychotherapies

The main differences between these therapies are listed below:

- Interpretations of unconscious material are given only in TFP.
- Supportive interventions are not provided by TFP, but may be offered by the other modalities.
- Designated treatment targets are explicitly identified by DBT, less so by other modalities.
- Attention to patient functioning is advocated by DBT, TFP and GPM.
- Multimodal treatment is offered mainly by DBT and MBT.

Discussion

It is striking that all empirically validated treatments for BPD offer the ingredients required to establish security of attachment together with those needed for the development of a capacity to reflect on the mind of self and other, i.e. to mentalise, which is itself dependent on security of attachment. Only MBT specifically names this development of the capacity to mentalise when the attachment system is aroused as the principal treatment aim,[13] yet every validated modality of psychotherapy promotes this capacity, albeit using different terminology.

This would suggest that provision of the ingredients required to develop secure attachment and the ability to mentalise when the attachment system is aroused can be reparative – or offer the conditions for repair – of developmental difficulties and failures. Some evidence is available for this in recent studies[14] although further evidence is required.

Good treatment for BPD requires an eclectic approach, incorporating aspects of different psychotherapeutic modalities according to individual patient needs. This may not require lengthy training. What is, in the end, most important for these patients is a collaborative, cooperative, empathic relationship with a reasonably skilled clinician, who strives to hold the patient's mind in mind.

It must be stressed that regular, usually weekly, psychotherapy for varying periods (usually 12–18 months) is offered not only by specific empirically validated psychotherapies for BPD, but also by the 'generalist' treatments studied.[5]Treatment for BPD in Australian public systems tends to lack consistent provision of psychotherapy. Sadly, it may also lack the adequately

structured, integrated, approach to treatment required for the patient to feel 'held' in the treatment overall.

Conclusion

Individual psychotherapy is the principal treatment for BPD. Several modalities of psychotherapy have been empirically supported by RCTs and the ingredients required for effective treatment of BPD identified.

Common factors in the empirically supported psychotherapies for BPD correspond to those required for the development of security of attachment and the capacity to reflect on the mind of self and others in an attachment context. These ingredients, together with adequate structuring of overall treatment to achieve integration and coordination across the treatment system, could, with sufficient determination, be offered both in public and private general psychiatric services in Australia.

Given this provision, the terrible emotional pain, maladaptive behaviours, and relationship difficulties experienced by people with BPD would lessen, leading them to more satisfying and fulfilling lives. Also diminished would be the demoralization of clinicians working within unstructured, uncoordinated systems of care for BPD. Many of the ingredients required for effective treatment of BPD in Australia are already offered, albeit often in an inconsistent, uncoordinated way. Change will require coordination, some training, and an effort of will. It can be performed and, once achieved, will deliver significant benefits to patients with BPD.

Disclosure

The authors report no conflict of interest. The authors alone are responsible for the content and writing of the paper.

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