Recent advances in psychosocial treatments for borderline personality disorder

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Abstract

In the past three years, several psychosocial treatments for borderline personality disorder have received empirical support. This review highlights findings from recent treatment studies and discusses how these findings have dramatically altered clinical practice for this disorder.

Introduction and context

Historically, borderline personality disorder (BPD) was viewed as a challenging and pervasive mental health disorder that was largely non-responsive to treatment [1]. Given that evidence-based treatments were not available and the fact that many clinicians held pessimistic views about people with the illness, diagnosis of the disorder was typically avoided. Consequently, persons with BPD did not receive adequate care and often experienced mistreatment by health care providers [1,2]. Over the past two decades, a growing body of evidence from treatment studies has dramatically altered views about the disorder. Positive results from treatment studies have also facilitated a shift in attitudes and practices for persons with BPD.

Recent advances

Extensive research findings support the use of a variety of clinical approaches for BPD ranging in theoretical orientation (for example, behaviour therapy, cognitive interventions, or psychodynamic approaches), duration (for example, 12 months or 20 weeks), and application (for example, inpatient, adjunctive treatments, or comorbid-specific). In addition, there are now studies that provide important information regarding the cost-effectiveness and long-term clinical outcomes associated with these interventions. The shift toward a more optimistic and compassionate attitude toward individuals with BPD stems largely from a growing body of empirical evidence in support of various approaches.

Cognitive behavioural interventions have received the most empirical support, with dialectical behaviour therapy (DBT) being the most extensively studied and disseminated approach [2,3]. Nine published trials demonstrate that DBT is associated with a significant decrease in the frequency and medical severity of suicidal and self-injurious behaviour, the number of inpatient psychiatric days, and reliance on psychotropic medications [4-12]. Also, trials examining adaptations of DBT across clinical settings and comorbid groups are promising, particularly among inpatient populations [13], adolescents [14], and those with eating disorders [15] and substance abuse [7,9,11].

Despite these impressive results, the standard DBT model (for example, 12 months of weekly individual therapy, skills training, phone skills coaching, and a therapist consultation team) is considered to be a resource-intensive treatment that requires substantial therapist training and involvement [1,16]. Unfortunately, most clinical settings lack the resources to apply the comprehensive package and/or train staff accordingly. Given these considerations, there is growing interest in developing and evaluating alternative therapeutic approaches for BPD. For example, alternative cognitive behaviour therapy (CBT)-based approaches, including schema-focused therapy (SFT), have received preliminary empirical support for the treatment of BPD. Although there have been critiques of this study [17], SFT was associated with greater treatment retention and

superior outcomes at 3 years post-treatment in a controlled multi-site clinical trial compared with transference-focused psychotherapy (TFP) [18]. The cost-effectiveness of these two treatments has also been examined, with SFT showing economic advantage over TFP [19]. A large multi-site study comparing 1 year of CBT plus treatment as usual (TAU) to TAU alone for individuals with BPD demonstrated that CBT was associated with superior treatment gains (for example, fewer suicidal behaviours), less symptom distress (for example, a reduction in anxiety and dysfunctional beliefs), and greater cost-effectiveness [20,21].

Interest in the feasibility and cost-effectiveness of the CBT-based STEPPS (Systems Training for Emotional Predictability and Problem Solving) program [22] continues to grow. Designed as an adjunct to ongoing clinical care, STEPPS is a 20-week manualized group intervention for outpatients meeting diagnostic criteria for BPD. Uncontrolled studies [23,24] and a recent randomized trial [25] have shown that STEPPS is associated with significant improvements across cognitive, emotional, and interpersonal domains. Compared with a control condition, participants exposed to STEPPS reported less impulsivity, a reduction in negative thoughts and feelings, and fewer emergency room admissions. Further support for STEPPS comes from a recently published uncontrolled pilot study in which STEPPS was administered in a forensic setting to 12 female offenders with BPD [26]. Participants reported less distress from BPD-related symptoms and improvements on negative affect and depression.

Additionally, there is growing evidence to support the clinical value of other, brief, skills-based group interventions (typically offered to supplement ongoing or standard care) in the treatment of BPD. Time-limited psychotherapy groups focusing on skill acquisition and adaptive functioning are among the most recognized treatment developments for BPD in recent years. DBT-informed skills training groups, delivered without standard DBT individual therapy, have been studied in several trials and have been shown to be associated with significantly fewer suicidal acts, self-injurious behaviours, and other impulsive self-destructive tendencies (for example, substance abuse, binge eating, and angry outbursts) in patients with BPD [27-29]. Likewise, a six-session manual-assisted cognitive therapy (MACT) intervention was associated with decreases in the frequency of self-injurious behaviours with treatment gains maintained at 6-month follow-up [30]. Gratz and Gunderson [31] evaluated the clinical effectiveness of a 14-week emotion regulation skills group for the treatment of self-injurious behaviour in women with BPD. The emotion

regulation group incorporated elements from DBT, acceptance and commitment therapy, and emotion-focused therapy, and focused on increasing emotional awareness, decreasing experiential avoidance, and teaching adaptive coping skills. Participants were randomly assigned to receive either the skills group in addition to current treatment or current treatment only. The treatment group showed significant reductions in self-injurious behaviour and improvements on measures of depression and anxiety, and demonstrated better ability to cope with negative emotions. Finally, education about their diagnosis can also be beneficial to patients diagnosed with BPD. A randomized trial by Zanarini and Frankenburg [32] demonstrated that individuals who were educated about the diagnosis of BPD in a psychoeducation workshop yielded significant improvements in general impulsivity and relational difficulties.

Recently, interest in the evaluation of psychodynamic treatments for BPD has emerged with several dynamically informed approaches demonstrating effectiveness with persons with BPD. TFP, studied in a randomized controlled trial, was compared with DBT and supportive treatment [33]. The three treatments showed comparable reductions on measures of depression, anxiety, and impulsivity, with the TFP and DBT groups showing the greatest reductions in suicidality. Mentalization-based day treatment (MBT) has also been studied and empirically supported in randomized controlled trials [34,35], and a recent follow-up study [36] demonstrated superior maintenance of treatment gains among those who received MBT. Compared with a control group, those assigned to MBT reported fewer suicide attempts, a reduced number of hospital and emergency room visits, a decreased use of psychotropic medications, and greater global functioning 5 years post-treatment. Thus, psychodynamic approaches continue to be among the forefront of innovative and efficacious treatments for BPD.

Efforts to evaluate potential mechanisms and moderators of change across treatment approaches have also received increased attention in recent years. For instance, researchers have demonstrated the importance of attachment and reflective functioning in TFP [37] and the role of enhanced self-concept and self-affirmation in DBT [38].

Implications for clinical practice

The rapid and growing interest in developing and evaluating clinical interventions for a population once viewed with reluctance reflects the changing and increasing optimism about this disorder. The growing empirical evidence for the efficacy of various treatment approaches for BPD indicates that it would be

considered standard clinical practice to encourage and facilitate the assessment and diagnosis of BPD. Moreover, with a greater availability of evidence-based treatments for BPD, potentially more individuals with the disorder will receive empirically supported treatment for their symptoms. Importantly, given that multiple structured approaches are associated with positive clinical changes in BPD, future research establishing mechanisms of change and long-term functioning will be essential [39,40]. For example, specific treatment approaches may be more effective with certain patient subgroups and/or levels of motivation for change [41]. While there is evidence for the economic benefit of using several longer-term psychotherapies (for example, DBT, SFT, or TFP), the support for time-limited group therapies is equally salient given the need to develop efficacious interventions that are more easily transportable and cost-effective. A number of treatments for BPD are now manualized to facilitate greater dissemination and easier implementation across clinical settings. Finally, in light of the emerging cost-effectiveness data and the consistent finding that several treatments are associated with decreased pain and suffering among those with BPD, these data have important implications for the provision of health care and medical insurance coverage.

Abbreviations

BPD, borderline personality disorder; CBT, cognitive behaviour therapy; DBT, dialectical behaviour therapy; MACT, manual-assisted cognitive therapy; MBT, mentalization-based day treatment; SFT, schema-focused therapy; STEPPS, Systems Training for Emotional Predictability and Problem Solving; TAU, treatment as usual; TFP, transference-focused psychotherapy.

Competing interests

The authors declare that they have no competing interests.

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