

# Treatment of Borderline Personality Disorder



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## KEYWORDS

- Borderline personality disorder • Psychotherapy • Treatment
- Dialectical behavior therapy • Mentalization-based therapy
- Transference-focused psychotherapy

## KEY POINTS

- There are several treatments for borderline personality disorder (BPD) that have shown efficacy in one or more randomized controlled trials; these treatments include those based on cognitive behavior theories (eg, dialectical behavior therapy [DBT] and schema-focused psychotherapy) and psychodynamic theories (eg, mentalization-based therapy and transference-focused psychotherapy).
- Regardless of theoretic origin, most treatments for BPD have been modified based on unique problems presented by the disorder and tend to be integrated to some degree, if not explicitly then implicitly.
- Randomized controlled trials and meta-analyses suggest that patients treated with one of these treatments are better off than those on waiting lists and in treatment as usual. Direct comparisons of active treatments, however, are uncommon and show few reliable differences.
- In addition to these specialty treatments, there are several generalist approaches and adjunctive treatments that show promise and could have widespread applicability. These include good psychiatric management, step-down treatment, Systems Training for Emotional Predictability and Problem Solving, and motive-oriented psychotherapy.
- Although DBT has been studied the most, a series of meta-analyses suggest little to no differences between any active specialty treatments for BPD; there are no differences between DBT and non-DBT treatments or between cognitive behavior theory-based and psychodynamic theory-based treatments. Thus, clinicians are justified in using any of these efficacious treatments and might consider developing expertise in more than one approach.

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Borderline personality disorder (BPD) is a serious mental health disorder characterized by instability in relationships, emotions, identity, and behavior.<sup>1,2</sup> Approximately 2% to 6% of the general population suffer from BPD,<sup>3</sup> which thus is more common than schizophrenia, bipolar disorder, and autism. Clinical studies have found that 15% to 20% of outpatients<sup>4</sup> and up to 25% of inpatients<sup>5</sup> are diagnosed with BPD. Health care providers should keep in mind that the risk of suicide in BPD is high. An estimated 60% to 85% of individuals with BPD attempt suicide once (mean = 3.3 suicide attempts<sup>6,7</sup>; 8% complete suicide).<sup>8,9</sup> In this article, the authors examine the major treatments developed for BPD. Treatment rationales, techniques, and evidence are described. Special attention is paid to identifying potential mechanisms of change, identifying predictors of long-term outcome, and prescriptive indications for patient-treatment matching. Similarities and differences between treatment approaches and outcome are highlighted. Commonalities across these treatments suggest several important evidence-based guidelines for integrated care.

BPD has historically been viewed as difficult to treat using either psychotherapeutic or psychopharmacologic treatment modalities. Patients with BPD have been noted to frequently not adhere to treatment recommendations, use services chaotically, and repeatedly drop out of treatment. Many clinicians are intimidated by the prospect of treating BPD patients and are pessimistic about the outcome of treatment. Therapists treating patients with BPD have displayed high levels of burnout and have been known to be prone to enactments and even engagement in iatrogenic behaviors. This perspective arose in part due to the publication of case material that tended to be focused on difficult cases and situations within cases. The publication of these cases, although selected and thus not representative of outcome, was important because it helped articulate problem areas for focus and the development of techniques to address these issues. It also contributed, however, to the belief that those diagnosed with BPD were difficult if not impossible to treat. Consistent with this there is little evidence demonstrating for the efficacy of standard forms of cognitive behavior therapy (CBT) and psychoanalytic/psychodynamic therapy (PDT) for treating BPD.<sup>10</sup>

In recent years, however, there has been a burgeoning empirical literature on the treatment of BPD. Beginning with Linehan's<sup>11</sup> seminal randomized controlled trial (RCT) of dialectical behavior therapy (DBT), there is now a range of treatments—deriving from both the cognitive behavior and psychodynamic traditions—that have shown efficacy in RCTs and are now available to clinicians. Some of these treatments were derived from the cognitive behavior tradition. The best known and most widely tested of these is DBT,<sup>11</sup> discussed later. Others include schema-focused therapy (SFT),<sup>12</sup> Systems Training for Emotional Predictability and Problem Solving (STEPPS),<sup>14</sup> emotion regulation group therapy,<sup>15–17</sup> and motive-oriented therapeutic relationship (MOTR).<sup>18</sup> Other BPD-specific psychotherapies were derived from the psychoanalytic/psychodynamic tradition. The best known are mentalization-based therapy (MBT)<sup>19</sup> and transference-focused psychotherapy (TFP),<sup>20–22</sup> both of which are discussed later. Another psychodynamic treatment of BPD, dynamic deconstructive psychotherapy, also has demonstrated efficacy.<sup>23</sup>

The results of these efficacy studies suggest important evidence-based principles. First, BPD is a treatable disorder. Second, because BPD is chronic, its treatment seems to require longer-term efforts (all efficacious approaches conceptualize treatment as a multiyear process) and high levels of intensity; nonetheless, important and significant gains can be made in a relatively short time. Third, therapists have a range of options across several orientations available to them and it is premature to foreclose on any one of the available options that have been tested. Although there have been few direct comparisons, enough data now exist from RCTs and meta-analyses to suggest that no one approach has been consistently found superior to another.

Treatments, such as DBT, schema-focused psychotherapy (SFT), MBT, and TFP, have been described as specialty treatments because they represent modifications of standard CBT and PDT developed specifically for BPD. Kernberg<sup>24</sup> began identifying modifications to standard psychoanalytic therapy during his time at the Menninger Clinic and as part of the Menninger Psychotherapy Research Project. He based these modifications on pragmatic observations and the differing developmental psychopathology of BPDs, as he articulated it, which required changes to the 1-size-fits-all psychoanalytic model at that time. These modifications included a more active stance, explicit setting of the frame, increased emphasis on life outside the therapy (eg, a focus on productive investments and developing a hierarchy for session focus that emphasized events outside session, such as suicidality), the explication and increased efforts to the maintenance of a nonjudgmental stance (called technical neutrality), and, relatedly, a de-emphasis on overt supportive techniques, and finally modifications to the interpretive process. Similarly, Linehan<sup>11</sup> describes developing DBT as a modification of standard CBT, which she believed was not well suited for BPD patients due to a host of different issues that these patients were grappling with. Thus, she developed structures and skill modalities that targeted the difficulties seen in BPD. Young,<sup>12</sup> in developing SFT, also modified the standard CT of Beck<sup>13</sup> for use with BPD patients.

In developing these specialized treatments, these clinical investigators either implicitly or explicitly modified and integrated perspectives outside their home orientations or developed techniques that were consistent with other orientations. Thus, each of these treatments is integrative. For example, in SFT, they explicitly acknowledge the integration of attachment theory and object relational approaches.

In this section, the authors focus on the following 3 treatments for BPD: DBT, MBT, and TFP. Each treatment and evidence for its efficacy in the treatment of BPD is first described and then similarities and differences across these 3 treatments examined.

## **DIALECTICAL BEHAVIOR THERAPY**

DBT is an integrative model that blends elements from traditional CBT with acceptance-based practice drawn from Zen and humanistic approaches. DBT originally developed within the context of treating BPD; however, it has evolved as a treatment of multidisordered, complex client populations. The DBT biosocial theory conceptualizes BPD as a disorder of pervasive emotional dysregulation characterized by high emotional vulnerability and deficits in the ability to modulate emotions.<sup>11</sup> Emotion regulation disturbances develop as a consequence of transaction between biological anomalies resulting in emotional vulnerability and a relational history characterized by invalidating experiences. Borderline symptoms are viewed as a by-product or consequence of dysregulated emotions. DBT targets all elements of the emotion regulation system, including cognitions, phenomenological experience, expressive–motor behavior, and action tendencies.

The DBT intervention framework dialectically balances a focus on change and acceptance/validation strategies. The overarching goal of all treatment interventions is to enhance emotion regulation. The treatment model balances a structured approach with therapist flexibility and responsiveness. The intervention framework is diverse and includes a broad range of change-based interventions, such as exposure-based procedures, problem assessment and solution analysis, exposure, and structural strategies, along with acceptance-based strategies, including validation and a reciprocal communication style. The focus on balancing change and acceptance cuts across DBT's 4 skills modules: mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness.

Standard DBT has multiple modes that address the following functions:

1. Improving capabilities and skills
2. Enhancing motivation to change
3. Generalizing treatment gains to the client's natural environment
4. Structuring the environment to facilitate and maintain progress
5. Enhancing and maintaining therapist motivation and capabilities

These functions are achieved through the treatments' 4 modes:

1. Weekly individual therapy session to focus on client motivation managing crises and addressing how to help the client develop a life worth living
2. A 2-hour weekly skills training group that emphasizes the acquisition of mindfulness, emotion regulation, interpersonal effectiveness, and distress tolerance skills and is designed to enhance capabilities
3. Access to client-therapist telephone consultation 24 hours a day to ensure
4. Weekly therapist consultation meetings to enhance therapist motivation and improve competence

Among psychotherapies for BPD, DBT has garnered the most robust evidence base. To date, 14 randomized clinical trials (RCTs) have examined the effectiveness of DBT for BPD (including BPD traits). Of these, 7 trials compared DBT with nonspecific controls for BPD.<sup>26-32</sup> The findings indicate that DBT is consistently superior to nonspecific comparators in reducing suicidal and self-harm behavior, health care utilization (eg, inpatient psychiatric hospital admissions and emergency department visits), Clarkin, and improving treatment retention. DBT in comparison to well-defined comparator treatments has also been examined in 8 RCTs.<sup>33-45</sup> DBT has been shown as effective as other well-structured treatments and is associated with improvement across a broad range of outcomes, including suicidal and self-harm behavior, health care utilization, symptoms (depression and anger), and general functioning. Furthermore, the effects of treatment are durable postdischarge.<sup>43</sup> Although general levels of functional impairment show improvement over the course of treatment, they remain poor post-treatment.

## DIALECTICAL BEHAVIOR THERAPY SKILLS ONLY

DBT skills training offered as adjunctive or stand-alone intervention has become increasingly popular. In the current health care climate of rising costs and limited resources, and with the demand for specialist services exceeding available resources, DBT skills groups are popular because they offer a less resource intensive alternative to standard DBT. DBT skills training groups are increasingly delivered across a variety of contexts, including residential, inpatient, addiction, correctional, forensic, and emergency room services. Skills training groups are easier to disseminate than standard DBT because they require fewer resources and less staff training.

Three RCTs have evaluated DBT skills-only groups for BPD. Soler and colleagues<sup>46</sup> compared 13 weeks of DBT skills training with standard group therapy for individuals diagnosed with BPD. The results indicated that the DBT skills group was superior to the standard group therapy on the following outcomes: BPD symptoms, depression, anxiety, anger, and affect instability. There were no between-group differences on suicidal and self-harm behavior although individuals were not specifically recruited for these behaviors and there was considerable between-subject variance. In another trial, which recruited suicidal and self-injuring BPD clients, Linehan and colleagues<sup>40</sup> randomly assigned participants to a 1 year of standard DBT, DBT skills group plus intensive case management, or DBT individual therapy. Participants enrolled in the

arms with skills training—standard DBT or DBT skills training plus intensive care management—had superior outcomes to DBT individual therapy.

In a third trial, McMMain and colleagues<sup>47–49</sup> randomized 84 chronically suicidal individuals diagnosed with BPD to 20 weeks of DBT skills training or an active wait-list condition. The DBT group had superior outcomes compared with the active wait-list control on the following outcomes: self-destructive (eg, suicidal and self-harm) behaviors, aggressive behavior (eg, anger), and coping skills (eg, distress tolerance and emotion regulation).

In sum, these trials suggest that DBT skills training as a stand-alone intervention may be especially helpful for high-risk behaviors and symptoms associated with the acute phase of BPD; further research is needed.

### MENTALIZATION-BASED THERAPY

MBT is a structured psychodynamic psychotherapy that has been applied in both individual and group formats. In this approach, many of the symptoms of BPD are viewed as resulting from a distortion of, or reduction in, a social cognitive capacity called mentalizing. Mentalizing is defined as the ability to understand the actions of oneself and others in terms of mental states, including both thoughts and feelings. This ability is viewed as critical to everyday interactions and impacts an individual's capacity to experience one's behavior as coherently organized by mental states and to experience oneself as differentiated from others. These capacities may readily be weakened in individuals with a personality disorder, particularly when faced with interpersonal stress, resulting in a loss of cognitive and emotional coherence and differentiation between self and other. In this framework, the symptoms of BPD are understood as resulting from deficits in mentalizing capacities that are particularly pronounced in affectively charged interpersonal situations as well as a pressure to externalize intolerably painful internal states.<sup>19</sup> These deficits are believed to result from disruptions in early attachment relationships.

The core goal of MBT is to improve clients' capacity to mentalize by helping them to regain mentalizing when it is lost, maintain it when it is present, and to increase clients' ability to maintain a mentalizing stance in situations where it otherwise might be lost. Given that clients with BPD are particularly likely to lose mentalizing in interpersonal situations, the relationship between client and therapist is a key area of focus. In this approach, it is thought to be especially important that the client experiences the therapist (or someone else) as keeping the client's mental state in mind.

MBT involves a collaborative and structured approach to working to gently expand mentalizing and helping the client to identify mental states that were previously outside the client's awareness. This approach involves the therapist exhibiting empathy and providing validation of the client's experience, clarifying and exploring the client's narrative, and identifying the affective focus of the session. The therapist then helps broaden the client's perspective on the events presented in the client's narrative by presenting alternative perspectives. The work to expand the client's mentalizing primarily focuses on the here and now of the session and gradually comes to involve relationships with core attachment figures and other key people in the client's life, how these relationships become activated with the therapist, and how they influence mentalizing. The therapist works to encourage mentalizing the therapeutic relationship and takes into account both transference and countertransference reactions, which are specifically defined in terms of technical application. As mentalizing improves, the client becomes increasingly able to alternative representations of important relationships.

The beginning of treatment in MBT involves the establishment of goals with the client. Initial goals are to include commitment to and engagement in treatment as

well as an agreement to reduce harmful and self-destructive behaviors. Attachment strategies activated in relationships are mapped out with the client and a joint formulation agreed. A longer-term goal is the improvement of personal and social relationships as well as engagement in constructive activity. MBT was initially developed and tested as an 18-month treatment program that included both group and individual sessions; however, in clinical settings, it has been offered for shorter periods of time and in formats that include only individual or group therapy. Currently, there is no research evidence regarding the optimal format or length of MBT treatment.

To date, 3 RCTs have tested the efficacy of MBT for the treatment of BPD. The first trial of MBT<sup>50</sup> compared it to treatment as usual and found MBT superior in reducing self-harm, suicidality, hospitalization, need for medication, and self-report measures of depression, anxiety, symptom severity, and social adjustment. These results were maintained at an 18-month follow-up<sup>51–57</sup> that also found continued improvement in social and interpersonal functioning. An 8-year follow-up study<sup>58</sup> found that MBT remained superior to treatment as usual in the following outcomes: suicidality, diagnostic status, outpatient service use, need for medication, and social adjustment. Another trial of 134 clients comparing MBT to a structured clinical management (SCM) outpatient program for the treatment of BPD<sup>59</sup> found that MBT was superior with regard to the following outcomes: suicidality, severe self-harm, and client-reported symptom severity, depression, interpersonal problems, and social adjustment. Results also suggested that the rate of change of symptoms differed based on treatment: in MBT, there was more rapid improvement in mood, interpersonal functioning, and social adjustment, whereas the rate of improvement in self-harm was slower in MBT (although the ultimate improvement was greater compared with the SCM group). A follow-up analysis examining clients from this trial with comorbid BPD and antisocial personality disorder found that MBT was also efficacious in reducing anger, hostility, paranoia, self-harm, suicide attempts, negative mood, general psychiatric symptoms, and interpersonal problems and in improving social adjustment in this subgroup of clients.<sup>60</sup> A more recent trial of 85 clients diagnosed with BPD compared MBT to a manualized supportive group therapy<sup>61,62</sup> and found that both treatments were associated with improvements in psychological and interpersonal functioning as well as a decrease in the number of criteria met for BPD; MBT was found to have superior outcomes in clinician-rated functioning. Treatment effects were found sustained 18 months after the trial, with three-quarters of both groups achieving sustained diagnostic remission, and half of the MBT group meeting criteria for functional remission (compared with less than one-fifth of the comparison group). Another relevant study examined MBT in the treatment of self-harming adolescents,<sup>63</sup> 73% of whom met criteria for BPD, and found MBT superior to treatment-as-usual in reducing self-harm, suicidality, and depression. Taken together, these results suggest that MBT is efficacious in treating BPD, including clients with comorbid antisocial personality disorder, and that improvements are sustained long after treatment has ended.

### **TRANSFERENCE-FOCUSED PSYCHOTHERAPY**

TFP is a principle-based manualized individual outpatient psychodynamic psychotherapy tailored specifically for the treatment of severe personality disorders, including BPD. It was developed based on Kernberg's<sup>25</sup> theory of the developmental origins of BPD, in which the symptoms of BPD are understood as arising from unintegrated affectively charged representations of self and others. This lack of integration means that totally negative representations of self and other—and the associated affects—are split off from totally positive representations, leading to instability in affects, identity, and relationships. The goal of

TFP is to integrate these unintegrated representations, leading to a more coherent sense of identity, better affect regulation, a reduction in self-destructive behavior, more balanced and constant relationships, and improved overall functioning.

The primary focus of TFP is on the affect-laden themes that arise in the relationship between client and therapist within sessions; attention is also paid to the client's life outside sessions. Sessions typically take place twice per week. The treatment begins with contract-setting that clarifies the therapeutic frame, the method of treatment, and the responsibilities of both client and therapist. In this contract-setting phase, the therapist is careful to elicit and address any concerns the client may have about the treatment frame. This treatment frame is intended to help contain the client's acting out behaviors. Particularly in the first year of treatment, TFP focuses on a hierarchy of treatment goals: addressing behaviors that pose a risk to self or others (including suicidal and self-destructive behavior), therapy-interfering behaviors, and identifying predominant object relational patterns as they emerge in the here-and-now transference relationship with the therapist.

To date, 3 trials have assessed the efficacy of TFP in the treatment of BPD. Two of these,<sup>36,64</sup> are discussed previously. In the Clarkin and colleagues<sup>36</sup> trial, although no treatment was found superior in terms of symptom change, TFP was found superior to both DBT and supportive psychodynamic (SPT) in terms of change in attachment patterns and reflective functioning,<sup>65</sup> which is consistent with the mechanisms of change hypothesized by the underlying theory of TFP. In another trial of 104 clients comparing TFP to treatment by an experienced community psychotherapist, TFP was found more efficacious in reducing suicide attempts, inpatient admissions, BPD symptoms, psychosocial functioning, and personality organization.<sup>66,67</sup> In summary, the results of these trials suggest that TFP is efficacious in the treatment of BPD symptoms and overall functioning and may be particularly efficacious in improving attachment patterns and reflective functioning.

In contrast to these specialty treatments, Gunderson and Paris independently have described what they call generalist approaches to psychotherapy and treatment of BPD. Gunderson with Links<sup>68</sup> developed what was originally called general psychiatric management, now named good psychiatric management (GPM). GPM was originally developed as a control condition for an RCT in comparison to DBT<sup>44</sup> and was based on recommendations from the *Guidelines for the Treatment of BPD* published by the American Psychiatric Association in 2001.<sup>69</sup> GPM served as an active and credible control in an RCT examining the efficacy of DBT. In that trial, no between-group differences were found across a broad range of outcomes at end of treatment (12 months) and 24 months postdischarge.<sup>43,44</sup> GPM has evolved since the original trial and what follows is a description of the treatment as it was evaluated.

GPM consists of 3 modes of intervention, including

1. Case management
2. Psychodynamically informed individual psychotherapy
3. Symptom-targeted medication management

Derived from the care promoted in the APA *Guidelines*, emphasizes psychotherapy as the first-line treatment of BPD. GPM's psychotherapeutic approach is well organized and informed by Gunderson's<sup>70</sup> psychodynamic approach treating BPD. The following principles guide the practice of GPM:

1. Clients are viewed and treated as competent adults.
2. Therapists are encouraged to be flexible in terms of the treatment focus.
3. Attention is accorded to client's role functioning.<sup>71,72</sup>

GPM conceptualizes intolerance of aloneness as the core problem underlying BPD. Disturbed attachment relationships contribute to the relational aspects of this disorder. Accordingly, the assessment of problematic patterns in relationships is a focus of treatment.<sup>70</sup> Emotion-processing problems figure centrally in disturbed attachment relationships and consequently GPM has an emotion focus.<sup>71</sup>

In the original trial, GPM was a comprehensive format involving weekly individual therapy sessions (50 minutes), weekly therapist group, and case management. There are a variety of treatment strategies in the model and these include responding to crises, safety monitoring, establishing and monitoring a therapeutic framework and alliance, educating the client and the client's family about the disorder, facilitating adherence to the treatment regimen, coordinating multimodal therapies, and monitoring clinical status and treatment plans. The GPM approach commonly includes medication management and in the original trial this was based on a symptom-targeted approach. Ancillary treatments are tailored to the client's needs and guided by a view that a multimodal and community approach is most effective with suicidal individuals.<sup>73</sup> In the GPM model, therapists are not available outside of working hours and clients are instead encouraged to exercise control over their behavior and seek out emergency services as needed.

With similar intentions, Bateman and Fonagy<sup>59</sup> in the United Kingdom developed a similar manualized approach for BPD that they called SCM, delivered by generalist mental health clinicians without specialist training. SCM was used as a distinct comparison treatment in an RCT comparing MBT for BPD.<sup>59</sup> Focusing less on psychodynamic relational elements in treatment and more on emotional management and impulse control than GPM, the treatment did remarkably well on self-harm and suicide attempts although it was less effective than MBT over time, particularly with the more severe clients.<sup>60,74,75</sup> SCM has been developed further<sup>74</sup> and is currently organized to meet the UK standards for treatment of BPD when delivered by nonspecialists within general mental health services.<sup>76</sup>

Another similar approach is the stepped care rehabilitation model articulated by Paris and colleagues<sup>77-79</sup> as an alternative to extended treatment of BPD. Paris notes that BPD is characterized by both acute and chronic phases. Although BPD presents significant clinical challenges in its acute phase, most patients show steady improvement over time and eventually recover or remit. Despite improvements, those with BPD show residual difficulties, particularly in work and relationships, which can benefit from further treatment. Paris<sup>77</sup> views this residual period as the chronic phase of BPD and suggests that BPD patients have available to them treatments that they can access intermittently on an as-needed basis. In this approach, Paris<sup>77</sup> contends that various empirically supported approaches and derived principles can be applied flexibly. Although no efficacy data from a RCT exist testing this approach, Paris<sup>77</sup> has presented pre-post data on 130 treated individuals. Paris<sup>77</sup> found reductions in somatization, obsessive-compulsive symptoms, interpersonal sensitivity, depression, anxiety, hostility, paranoia, and psychoticism on the Symptom Checklist-90. Additionally, there were reductions in depression, impulsivity, dysfunctional attitudes, and number of emergency department visits and hospital admissions. These findings notwithstanding, this treatment awaits further testing using more rigorous designs that control for issues that pre-post designs cannot account for (eg, regression to the mean).

In addition to the treatments discussed previously, there is preliminary evidence to support other treatments for BPD based on studies using pre-post or quasiexperimental designs or in case studies or in RCTs with ambiguous results. These include the conversational model,<sup>80</sup> cognitive analytical therapy,<sup>81</sup> modified cognitive therapy,<sup>82</sup> clarification-oriented psychotherapy,<sup>83</sup> interpersonal psychotherapy,<sup>84</sup> interpersonal group psychotherapy,<sup>85</sup> and emotion-focused psychotherapy.<sup>86</sup>



## DIRECT COMPARISONS

Although most trials of psychotherapies designed specifically for the treatment of BPD have compared these BPD-specific treatments to treatment as usual or a non-BPD-specific treatment, a few trials have directly compared the efficacy of BPD-specific treatments. One trial<sup>64,87</sup> comparing TFP and SFT found that both treatments were efficacious in reducing general and BPD-specific symptoms and improving quality of life but found SFT superior at the 3-year mark with regard to these outcomes, although the TFP cell contained more suicidal patients and showed less adherence.<sup>88,89</sup> Similarly, the therapeutic alliance was rated as higher in SFT compared with TFP,<sup>90</sup> although many of the alliance ratings were made after dropout. Another trial<sup>36</sup> compared TFP, DBT, and an SPT designed for the treatment of BPD (SPT). Results suggested that all 3 treatments (TFP, DBT, and SPT) were generally equivalent in showing statistically significant improvement in multiple symptom domains relevant to BPD, whereas TFP was found superior to both DBT and SPT in terms of change in attachment patterns and reflective functioning.<sup>65</sup> Finally, a year-long trial of 180 clients compared DBT to GPM and found both efficacious in treating suicidal behavior, borderline symptoms, general distress, depression, anger, and health care utilization and in improving interpersonal functioning.<sup>44</sup> A 2-year follow-up study<sup>43</sup> found that these improvements either continued or were sustained over follow-up. Neither treatment was found superior to the other.

## META-ANALYSES

As research has been conducted examining the efficacy and effectiveness of psychotherapeutic treatments for BPD, researchers have begun to use systematic reviews and meta-analyses to examine whether any conclusions and recommendations can be drawn from the existing literature. Binks and colleagues<sup>90</sup> initially conducted a systematic review of 7 studies of psychotherapy for BPD, 6 of which were of DBT trials. Although there was evidence of moderate effect sizes (ESs), the confidence intervals were so large as to render the interpretations unreliable. Thus, these investigators concluded that therapy may help treat some problems experienced by BPD clients, including self-harm, hospital admission, depression, and anxiety; however, because of the large confidence intervals, they cautioned that all treatments “remain experimental”.<sup>90[p21]</sup> Subsequently, a meta-analysis focused on trials examining the efficacy of DBT<sup>91</sup> found a moderate ES of .39 across 16 studies. Moderator analyses, however, revealed a difference in ES depending on whether the comparison condition was a BPD-specific treatment; the ES was estimated at .51 when DBT was compared with psychotherapies not specifically intended for the treatment of BPD (eg, treatment as usual), but the ES was not significant (estimated at 0.01) when DBT was compared with other BPD-specific treatments, such as TFP or GPM. A later review and meta-analysis of treatments for BPD<sup>92</sup> found there were indications of beneficial effects for comprehensive psychotherapies (defined as treatments where individual psychotherapy was a substantial part of the treatment). Additionally, noncomprehensive psychotherapeutic interventions (treatments where individual psychotherapy was not a substantial part of the treatment, such as psychoeducation and skills training) were also helpful although they were evaluated in only a few trials. The investigators noted that although DBT has been studied most intensely, followed by MBT, TFP, SFT, and STEPPS, they did not consider any of the treatments to have a robust base of evidence and raised concerns about the quality of individual studies. The investigators concluded that psychotherapy is critical to the treatment of BPD; however, replication studies are needed.

More recently, Cristea and colleagues<sup>93,94</sup> conducted a meta-analysis of 33 trials and more than 2000 clients. They found small-to-moderate ESs—ranging between .32 and .44—across types of psychotherapies and outcome variables. No difference was found between DBT and psychodynamic approaches. The investigators concluded that psychotherapy is effective for treating BPD symptoms but cautioned that effects were small, may be inflated by risk of bias and publication bias, and may not be stable at follow-up.

Levy and colleagues<sup>95,96</sup> have also recently completed a comprehensive meta-analysis and metaregression examining treatment of BPD. Levy and colleagues<sup>95</sup> undertook a different approach in that they gathered all studies of psychotherapy for BPD regardless of randomization. In total, they identified 73 unique studies that included more than 1700 patients. By including a wide range of studies with diverse methods, Levy and colleagues<sup>95</sup> were able to examine methodological moderators in addition to study and patient moderators. Although the within-group effects were large ( $ES = .86$ ), the between-group effects were more moderate. Across all controlled studies, the  $ES = .36$ , translating into an effect of number needed to treat (NNT) of 8. Compared with TAU, however, the ES increased to 498 and the NNT became a more robust 5. Compared with wait-list controls, the  $ES = .646$ , and the NNT was 4. There were no differences between PDT and CBT treatments or between DBT and other treatments. There was no difference in independently and reliability-rated quality of studies between PDT and CBT. The only consistent moderators were methodological ones: in addition to control condition reported earlier, higher study quality led to weaker effects, dichotomous outcomes had larger effects, observer-rated outcomes had larger effects than self-report, nonblind raters had larger effects, and completer analyses showed larger effects.

## TREATMENT GUIDELINES

There are several treatment guidelines and reviews, including the Society of Clinical Psychology Committee<sup>97</sup> on Science and Practice, the United Kingdom National Institute for Health and Care Excellence guidelines,<sup>75</sup> the Cochrane Collaboration reviews,<sup>54</sup> and the Netherlands Multidisciplinary Directive for Personality Disorders,<sup>98</sup> the National Health and Medical Research Council of the Australian Government Clinical Practice Guideline<sup>99</sup> for the Management of Borderline Personality Disorder. These guidelines tend to be consistent in recommending the big five psychotherapies (DBT, MBT, TFP, SFT, and GPM) for treating BPD.

## EVIDENCE-BASED CONCLUSIONS

There are several treatment implications of this review. First, there are multiple treatments available to patients with BPD and the clinicians who treat them. Although these treatments derive out of different theoretic orientations and do have some differences, they all tend to be integrative, either explicitly or implicitly. Despite the use of different terms and jargon, there are more similarities across these treatments than is often recognized. This may be in large part given that these treatments are derived from similar clinical experiences in adapting to the challenge of treating clients with BPD, and treatments have been developed and refined in part based on knowledge derived from the broader literature on psychotherapy for BPD. All these treatments tend to be long term, with clinical trials lasting 12 months to 18 months and naturalistic treatment often lasting longer. All 3 include the provision of supervision and consultation for therapists (or intervention for more experienced therapists), with the explicit goal of protecting against therapist burnout, enactments, passivity, iatrogenic behaviors, and

colluding with clients' pathology. Similarly, to avoid splitting across providers, each treatment emphasizes integration of different services received by clients and communication among providers. Each treatment is based on a coherent and principle-based theoretic model that guides interventions and is presented to the client so that it makes sense to both the therapist and the client. Additionally, each of these treatments pays a great deal of attention to the structure and frame of therapy: the roles and responsibilities of both client and therapist are clearly established, a great deal of time is dedicated to discussing the treatment frame and addressing treatment-interfering behaviors, and there is a clear focus and set of priorities in treatment to guide the focus of individual sessions. In particular, all treatments involve a commitment to reduce self-destructive behaviors. In both TFP and DBT, there is an explicit focus on prioritizing, respectively, self-destructive behaviors, therapy-interfering behaviors, and behaviors that interfere with quality of life, including a detailed analysis of events when the client does engage in these behaviors. Further, although the reduction of self-destructive behavior is a top priority in each of these treatments, so too is comprehensive change above and beyond symptom reduction. MBT focuses on developing the capacity to mentalize that contributes to intrapersonal and interpersonal functioning, DBT builds toward a "life worth living," whereas TFP aims for clients to develop the capacity "to love and to work." Additionally, each of these treatments places a great deal of emphasis on the therapeutic relationship. Another commonality across these treatments is facilitating the client integrating disparate views, particularly in the context of intense affect, whether via dialectical thinking (DBT) or the exploration of possible alternative perspectives (TFP and MBT).

In these treatments, therapists to take an active role in treatment, adopt a nonjudgmental and flexible stance and to empathize with the client without reinforcing distortions in the perception of self or others. Many treatments for BPD use group therapy in addition to individual therapy: DBT includes skills groups, MBT has traditionally included group therapy, and STEPPS and emotion regulation group therapy are group psychotherapies for BPD. Other forms of treatment, such as dynamic deconstructive psychotherapy, may encourage but not require involvement in group psychotherapy. Additionally, there is a common focus on emotion regulation, views of self and other, and on addressing unintegrated or polarized mental states. The specific form this takes may differ by treatment; for instance, DBT focuses on dialectical thinking, TFP focuses on vacillations in object-relations dyads (affectively charged representations of self and other in relationship) and in integrating self and other representations, whereas SFT focuses on abrupt shifts between schema modes (thoughts, behaviors, and emotions that reflect the emotional/behavioral state of the person at any given moment). MBT emphasizes shifts in mentalizing from effective mentalizing process to nonmentalizing modes. Furthermore, there is a common focus on helping clients to link and integrate their emotions, thoughts, and behaviors. Finally, treatments for BPD generally include a focus on self-observation as well as considering alternative perspectives. Despite this evidence, at this point there are few prescriptive indicators suggested in the literature.

Second, there seem few reliable differences between these treatments when well delivered. In the absence of evidence supporting the superiority of one psychotherapy approach over another, an effective system of care for BPD should include multiple treatment options. Some clients have preferences for specific therapeutic models and this issue warrants consideration. Research on client preference indicates that preferences may have an impact on treatment engagement and the development of a positive therapeutic alliance<sup>100-104</sup> and, therefore, client preferences for specific approaches may be relevant to treatment planning.

Additionally, BPD, like many other disorders, is heterogeneous. As such, it would be shortsighted to think that one treatment approach is best for all presentations. It is likely that some patients might do better in an MBT approach, others DBT, and still others in TFP. At this point, little is known about which type of borderline patients will do best in which specific treatments. Brief treatments and nonspecialty treatments, such as GPM, SCM, and step-down care, are an important part of a broader continuum of care and an alternative to evidence-based lengthy structured treatments. There is growing evidence for the efficacy of abbreviated and adjunctive treatments, such as DBT skills training, STEPPS, emotion regulation groups, and MOTR. Access to comprehensive, lengthy treatments is a global problem due to limited resources, a shortage of well-trained clinicians, and wait-lists. Because evidence-based comprehensive structured treatments for BPD can be costly and complex to deliver to all clients who need it, brief skills-based treatment models may play an important role. Brief interventions are more feasible to implement and disseminate, especially within poorly resourced health care contexts. Furthermore, brief treatments may be suitable for some clients, especially those with less severity and chronicity.

Nonetheless, many patients may desire or require more lengthy and intensive treatments. Given the relative equivalence of the various treatments, patient preferences, limited resources, and patient heterogeneity, it is important for communities to have more than one type of treatment available, most likely from different perspectives (eg, CBT vs PDT). Additionally, individual therapists and their patients may benefit from treaters knowing and having been trained in more than one type of treatment. Increasingly, training institutions and therapists are learning more than one modality. This allows them to integrate various aspects of the treatments, to sequence treatments, and to be responsive to patient needs.

In sum, there are several treatments available to the practicing clinician. The big five psychotherapies for treating BPD are

1. DBT
2. MBT
3. TFP
4. SFT
5. GPM (with PDT)

Outcome data, direct comparisons, and meta-analyses all suggest few reliable differences between these treatments and that no one treatment is more effective than the other. In addition, there are several adjunctive treatments (DBT skills group, STEPPS, and MOTR) that may be useful. Finally, there are several other treatments that show promise and warrant additional study.

Despite these conclusions, treatment research for BPD is relatively impoverished compared with other conditions. This relative lack of research has impeded the field. What is needed are large-scale, multisite studies that compare 2 active treatments with enhanced treatment as usual that allow making inferences about noninferiority and examine moderators.<sup>105–107</sup> Studies selecting patients based on prescriptive indicators would be useful too and allow answering Gordon Paul's<sup>78</sup> iconic question, What treatment, by whom, is most effective for this individual, with that specific problem, and under which set of circumstances?

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