Personality and Mental Health
4: 54–58 (2010)
Published online in Wiley InterScience
(www.interscience.wiley.com) DOI: 10.1002/pmh.119

Commentary
UK National Institute for Clinical Excellence guidelines for the treatment of borderline personality disorder

KENNETH N. LEVY[1], FRANK E. YEOMANS[1], FRANK DENNING[2] AND ERIC A. FERTUCK[3],
[1]Department of Psychiatry, Weill Medical College of Cornell University; [2]Manchester, England;
[3]Department of Psychiatry, Columbia University and New York State Psychiatric Institute, USA.

In the UK, the National Institute for Clinical Excellence (NICE) has a very powerful influence on treatments that are delivered by the National Health Service throughout all fields of medicine and mental health. Whenever a clinician in the UK is making a decision as to the most appropriate treatment to offer a patient they are expected to bear in mind what the guidance recommends. The establishment of such guidelines can be of great benefit to clinicians, and it is encouraging that borderline personality disorder (BPD) has been recognized as warranting this attention. To our knowledge, this is the first set of treatment guidelines created specifically for BPD for a government-run, nationalized health service (NHS). All previous recommendations for BPD have come from independent professional organizations or non-government organizations that do not specifically recommend to a national health service. As such, this is a highly commendable, landmark opportunity for widespread implementation of effective treatments to a much underserved and often stigmatized group of individuals: those with BPD and Antisocial Personality Disorder (ASPD). Additionally, we applaud the thoughtful and thorough approach that the NICE guideline developers took to insure a comprehensive and clinically flexible set of guidelines that adheres closely to the empirical literature.

There are three published versions of the guidelines. One is a brief guide called the Quick Reference Guide and is the one most likely to be consulted by clinicians considering which treatments to offer. The other two are the full guidance and the NICE guidance. The full guideline documents are quite involved and contain a huge amount of information that is daunting to even the most knowledgeable practitioners.

The NICE guidance is based on peer-reviewed research evidence. Randomized controlled trials (RCTs) are considered the gold standard studies to establish the empirical support for a particular treatment. NICE assembles a team of experts to draw up the guidance. The treatments that make it into the final guidance must meet rigorous standards in terms of what is considered reliable outcome data. The NICE guidelines join at least three other already existing guidelines: those developed by the American Psychological Association task force, the American Psychiatric Association Workgroup Group Practice Guidelines for the Treatment of Patients with BPD and The Cochrane Reviews. Using slightly different criteria for evidence (e.g. meta-analytic data), different

formats (levels of evidence vs. thresholds) and different interpretations of data, these organizations derive somewhat different judgments and recommendations. Of course, more guidelines may follow.

Our commentary on the guidance cannot be comprehensive because of space limitations. However, we hope to highlight some important aspects of this document and to communicate some concerns and suggestions that may aid clinicians utilizing the NICE guidelines. We also make recommendations for future revisions and on foci for research on the optimal treatment for BPD.

Restriction of treatment options

The quick guidelines, despite the best intensions of the committee, may lead to a premature narrowing of treatment options, particularly for suicidal women with BPD. The only treatment directly mentioned in the quick guidelines is Dialectical Behaviour Therapy (DBT), which is referred to as the treatment of choice for women with BPD when self-harm is central to the clinical presentation. We are concerned that other empirically supported treatments are not explicitly mentioned. The NICE guidelines may have the effect of limiting the options of patients and clinicians grappling with BPD by implying that DBT is the only treatment that is efficacious.

Although DBT appears to be a solid treatment that has marshalled a large amount of evidence for its efficacy—a larger number of clinical trials than any other treatment for BPD to date—it would be unfortunate to close off or limit access to the various other treatments that have also been shown to be efficacious or show promising empirical support. Only about 50–60% of patients improve in any of the treatments examined so far, including DBT (Levy, 2008). Thus, clinicians ideally need an array of treatment options for individuals with BPD who do not respond, or partially respond, to a particular treatment. The good news for those suffering from BPD is that the field now offers a range of treatments available which have shown promising results. These include mentalization-based therapy (MBT), schema-focused psychotherapy, system training for emotional predictability and problem solving, transference-focused psychotherapy (TFP) and specific forms of cognitive behavioural therapy developed for BPD patients (Levy, 2008; Sneed, Fertuck, Kanellopoulos, & Culang, in press).

At this point, the evidence is also very strong for the value of MBT in reducing suicidality and non-suicidal self-injury (NSSI). Additionally, despite early results in small sample studies that suggested that DBT might have specific effects with regard to parasuicidality, recent findings examining DBT in large groups suggest that it may not have these specific effects (Clarkin, Levy, Lenzenweger, & Kernberg, 2007; Linehan et al., 2006; McMain et al., 2009; Verhuel et al., 2003). For instance, Clarkin et al. found that both TFP and DBT reduced suicidality and that there were no differences in the reduction of suicidality between the two treatments. Finally, with regard to the just recently published McMain study, practice guidelines based on the American Psychiatric Association recommendations resulted in equivalent reductions to DBT in suicidality. These findings suggest that DBT may not be superior to other structured, coherent, well-delivered treatments that focus on reducing suicidality and NSSI.

Additionally, while the effectiveness of DBT has been demonstrated in a number of RCTs, there is no credible evidence from response rates, effect sizes or direct comparison with bonafide treatments that any one approach, including DBT, is better than another. At the very least, other empirically supported treatments should be considered when a patient does not respond to DBT or when DBT is not available in the patient's catchment area.

Emphasis on short-term symptom reduction and neglect of long-term stability of treatment gains

It is of some concern that the NICE recommendation is effectively about symptom management as

DOI: 10.1002/pmh

opposed to addressing long-term changes in stable functioning, as indicated by improved adaptation in personality and interpersonal functioning. Findings from the Collaborative Longitudinal Personality Disorders Study (Skodol et al., 2005) and the McLean Study of Adult Development (Zanarini, Frankenburg, Hennen, Reich, & Silk, 2005) indicate that symptomatic and diagnostic improvement does not necessarily result in social and functional improvement.

Moreover, although the improvement in suicidality, NSSI and some symptoms from DBT is clearly documented in the first 6–12 months of treatment, maintenance of improvement from follow-up data is, at best, uneven (Levy, 2008). By contrast, the follow-up data on MBT is impressive and only MBT has been shown to have long-term efficacy over several years—particularly important for chronic and long-standing problems like BPD.

Another question concerning the guidelines has to do with not including some important findings from already published studies. When the BPD draft guidelines were published in January 2009, the most up-to-date research on TFP (Levy et al., 2006a; Clarkin et al., 2007) was not included. The guidelines, therefore, do not include the noteworthy finding that TFP has been shown to improve patient's capacity for reflectiveness, an ability that is hypothesized to be one possible root of the many difficulties in BPD (Fonagy, Gergley, Jurist, & Target, 2002), and that fMRI studies are beginning to show is a deficit in BPD (e.g., Koenigsberg et al., 2009) and may be related to the long-term maintenance of treatment effects (Levy, 2008). Along these lines, Howard and colleagues (Howard et al., 1996) suggested a three-phase dose-response model of psychotherapy in which patients initially experience remoralization (the initial boost experienced from the feeling that help is there), followed by remediation (symptom reduction) and finally rehabilitation (establishing adaptive ways of living, also conceived of as personality change). Rehabilitation may be enhanced by symptom change but is especially likely to be the result of internal psychological change. TFP stands alone in having evidence of such change in terms of an increase in reflective functioning after 1 year of treatment.

Integration of new findings

Another issue is about how and when new information from studies published after the guidelines were written will be integrated into future revisions. Compared with other disorders such as major depression, the research base for BPD is very small. In addition, it is growing at a relatively rapid pace, with several new treatment studies either recently published or in review. It is possible to fill in for some of these limitations by referring to new data that is emerging at an encouraging pace and that was not available when the guidelines were being written (Bateman & Fonagy, 2009; Cottraux et al., 2009; Doering et al., in press; McMain et al., 2009). Two studies in particular that have been published since the January 2009 publication of the guidelines (Bateman & Fonagy, 2009; McMain et al., 2009) have significant implications for the treatment guidelines for BPD, and a third important study is under review (Doering et al., in press). These studies provide added support for three additional treatments for BPD.

Beyond considering specific treatment models, a considerable strength of the NICE guidelines is the emphasis on some principles of effective treatment that are likely to help patients with BPD, regardless of the label of the treatment. They recommend that treatment should be no less than 3 months in duration, and there is a comment about 12 months or so being a better length of therapy. There is also a suggestion that twice-weekly therapy should be considered. In addition, the guidelines are quite strong in all the areas beyond recommending specific treatments and addressing general treatment principles. They cover a wide range, including dealing with crises, endings and transitions, the need for a coherent model and how teams should work together.

Looking to probable future developments in research on BPD, it is likely—given the heteroge-

DOI: 10.1002/pmh

neity of BPD—that there are patient characteristics that will predict which patients would do better in which treatment (Levy, 2008). These patient characteristics may provide both prognostic indicators and prescriptive indicators answering the now 40-plus year-old question put forth by Gordon Paul (1967) of 'what treatment, by whom, is most effective with this individual, with that specific problem, under which set of circumstances?'.

In addition, as all the NICE guidelines are designed to be considered when offering treatments on the NHS, i.e. free at the point of delivery, there is a need to consider the cost of treatment. The aim is that local NHS Trusts take cost into account when deciding on which treatments to offer. This brings us back to the discussion above, distinguishing among remoralization, remediation and rehabilitation. In making these decisions, will the system aim for rehabilitation or take the position that remediation is all that it can offer? There is some risk that treatments that might be more costly in the short run will be eschewed, even if these treatments may lead to deeper and more stable improvement and reduce health-care costs in the long run.

Conclusion

The guidelines represent an important and landmark effort in reviewing and summarizing the currently available data that is relevant to the effective treatment of patients with BPD, and making recommendations that are to be implemented in national, government-run health care system. There is an inevitable tension between publishing guidelines that are definitive and the need to integrate constantly appearing new data into clinical care decisions. Particularly for an understudied disorder like BPD, flexibility in integrating new research will be of paramount importance in clinical care. To this end, NICE does make specific recommendations regarding future research, and in this respect, the guidelines can be seen as providing the stimulus for further research.

With regard to future research, it is important to note that NICE seems to be focusing on symptom reduction in the first 6–12 months, however, equally important is stable long-term change. Longer-term change may occur at the level of personality functioning, and it would be wise to invest research resources into developing treatments that target psychological and emotional processes that underlie the behavioural problems and symptoms such as affective instability and dysphoria.

More research is also needed on the specific mechanisms of therapeutic change for BPD (Kazdin, 2007; Levy et al., 2006b). Understanding the mechanisms through which a treatment operates is likely to facilitate the development of more advanced treatments that will yield larger effects, as active components are identified, intensified and refined, whereas inactive or redundant elements could be discarded or the focus reduced.

Finally, it is encouraging that, given the strong emphasis on scientific evidence, these sentences appear in the guidelines for BPD: 'Guidelines are not a substitute for professional knowledge and clinical judgement. They can be limited in their usefulness and applicability by a number of different factors: the availability of high-quality research evidence, the generalisability of research findings and the uniqueness of individuals with borderline personality disorder' (NICE, full guidelines on BPD, page 11). We hope that, at the level of the individual patient with BPD and his or her clinician, treatment recommendations and plans will ultimately be made based on the expertise and experience of the clinician as applied to the unique characteristics and circumstances of the patient, while keeping in mind the state of empirically supported treatments for BPD.

References

Bateman, A., & Fonagy, P. (2009). Randomized controlled trial of outpatient mentalization-based treatment versus structured clinical management for borderline personality disorder. *American Journal of Psychiatry*, 166, 1355–1364.

Clarkin, J. F., Levy, K. N., Lenzenweger, M. F., & Kernberg, O. F. (2007). Evaluating three treatments for borderline personality disorder: A multiwave study. *American Journal of Psychiatry, 164*, 922–928.

Cottraux, J., Note, I. D., Boutitie, F., Milliery, M., Genouihlac, V., Yao, S. N., Note, B., Mollard, E., Bonasse, F., Gaillard, S., Djamoussian, D., de Mey Guillard, C., Culem, A., & Gueyffier, F. (2009). Cognitive therapy versus Rogerian supportive therapy in borderline personality disorder: Two-year follow-up of a controlled pilot study. *Psychotherapy and Psychosomatics, 78*, 307–316.

Doering, S., Horz, S., Rentrop, M., Fischer-Kern, M., Schuster, P., Benecke, C., Buchheim, A., *et al.* (in press). A randomized controlled trial of transference-focused psychotherapy vs. treatment by experienced community psychotherapists for borderline personality disorder. British Journal of Psychiatry.

Fonagy, P., Gergely, G., Jurist, E., & Target, M. (2002). *Affect Regulation, Mentalization, and the Development of the Self.* New York: Other Press.

Howard, K. I., Cornille, T. A., Lyons, J. S., Vessey, J. T., Lueger, R. J., & Saunders, S. M. (1996). Patterns of mental health service utilization. *Archives of General Psychiatry, 53*, 696–703.

Kazdin, A. E. (2007). Mediators and mechanisms of change in psychotherapy research. *Annual Review of Clinical Psychology, 3*, 1–27.

Koenigsberg, H. W., Siever, L. J., Lee, H., Pizzarello, S., New, A. S., Goodman, M., Cheng, H., Flory, J., & Prohovnick, I. (2009). Neural correlates of emotion processing in borderline personality disorder. *Psychiatry Research: Neuroimaging, 3*(30), 192–199.

Levy, K. N., Meehan, K. B., Kelly, K. M., Reynoso, J. S., Weber, M., Clarkin, J. F., & Kernberg, O. F. (2006a). Change in attachment patterns and reflective function in a randomized control trial of transference focused psychotherapy for borderline personality disorder. *Journal of Consulting and Clinical Psychology, 74*, 1027–1040.

Levy, K. N., Clarkin, J. F., Yeomans, F. E., Scott, L. N., Wasserman, R. H., & Kernberg, O. H. (2006b). Mechanisms of change in the treatment of borderline personality disorder with transference focused psychotherapy. *Journal of Clinical Psychology, 62*, 481–501.

Levy, K. N. (2008). Psychotherapies and lasting change. *American Journal of Psychiatry, 165*, 556–559.

McMain, S. F., Links, P. S., Gnam, W. H., Guimond, T., Cardish, R. J., Korman, L., & Streiner, D. L. (2009). A randomized trial of dialectical behavior therapy versus general psychiatric management for borderline personality disorder. *American Journal of Psychiatry, 166*, 1365–1374.

Paul, G. L. (1967). Strategy of outcome research in psychotherapy. *Journal of Consulting Psychology, 31*, 109–118.

Skodol, A. E., Gunderson, J. G., Shea, M. T., McGlashan, T. H., Morey, L. C., Sanislow, C. A., & Stout, R. L. (2005). The Collaborative Longitudinal Personality Disorders Study (CLPS): Overview and implications. *Journal of Personality Disorders, 19*, 487–504.

Sneed, J. R., Fertuck, E. A., Kanellopoulos, D., & Culang, M. E. (in press). Borderline personality disorder. In P. Sturmey & M. Hersen (Eds.), *Handbook of evidence-based practice in clinical psychology. Volume 2, Adults.* Hoboken, NJ: Wiley.

Zanarini, M. C., Frankenburg, F. R., Hennen, J., Reich, D. B., & Silk, K. R. (2005). The McLean Study of Adult Development (MSAD): Overview and implications of the first six years of prospective follow-up. *Journal of Personality Disorders, 19*, 505–523.

Address correspondence to: Kenneth N. Levy, Department of Psychology, Pennsylvania State University, University Park, PA 16802, USA. Email: klevy@psu.edu

DOI: 10.1002/pmh