

Treatment Approaches for Borderline Personality Disorder

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Borderline personality disorder (BPD) is the only disorder to date for which the American Psychiatric Association's (APA) treatment guidelines specify psychotherapy as the treatment of choice.¹ Over the past decades, many evidence-based therapies have been developed to address BPD: psychotherapies based on cognitive-behavioral models (dialectical behavior therapy and schema-focused therapy) and on psychodynamic models (mentalization-based therapy, transference-focused

psychotherapy, and dynamic deconstructive psychotherapy).²⁻⁶

Although cognitive-behavioral therapies (CBTs) and psychodynamic therapies represent different viewpoints, both models share certain basic tenets in the treatment of patients with BPD.⁷ In this article, we review the treatments with a strong evidence base and discuss some of the therapies that offer promise but do not yet have a rigorous evidence base.

Cognitive-behavioral therapies

Dialectical behavior therapy and schema-focused therapy are two evidence-based therapies founded on modified CBT principles. To date, no stan-

dard CBT treatment has shown efficacy in a randomized controlled trial (RCT), although these modified approaches share many core features of a CBT approach, including teaching patients how to recognize, manage, or modify painful mental states.

CBT-based treatments address deficits in skills needed to tolerate intense affects and distortions in thinking and, in the case of schema-focused therapy, provide a reparative emotional experience. These therapies seek to identify dysfunctional beliefs in patients with BPD; these beliefs include seeing themselves as a combination of undesirable, needy, helpless, bad, unlovable, and deserving of punishment, and seeing others as



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DISCLOSURES

Drs Yeomans, Levy, and Meehan have no relationships to disclose relating to the subject matter of this article.

Applicable CME LLC staff have no relationships to disclose relating to the subject matter of this activity.

This activity has been independently reviewed for balance.

TARGET AUDIENCE

This continuing medical education activity is intended for psychiatrists, psychologists, primary care physicians, physician assistants, nurse practitioners, and other health care professionals who seek to improve their care for patients with mental health disorders.

GOAL STATEMENT

This activity will provide participants with a better understanding of personality disorders and what the impending changes will be in DSM-5, which, in turn, should help psychiatrists differentiate among the available treatment options.

ESTIMATED TIME TO COMPLETE

The activity in its entirety should take approximately 90 minutes to complete.

LEARNING OBJECTIVES

After completing this activity, participants should be able to:

- Understand the various evidence-based therapies used to treat borderline personality disorder
- Better understand the safety and efficacy profiles of the different therapeutic options
- Recognize the most suitable therapy for individual patients

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neglectful, untrustworthy, rejecting, or harmful. Addressing these beliefs and skills deficits functions to decrease helplessness and increase a sense of self-efficacy and mastery.

Dialectical behavior therapy. This model views emotional dysregulation as at the core of BPD, which is seen as developing from the combination of a genetic tendency to intense emotional reactions and an early environment that does not validate the individual's emotional experience. The term "dialectic" refers to the combining of and alternating between the therapist's acceptance of the patient as is (the context of emotional validation) and active encouragement toward behavioral change. Dialectical behavior therapy provides 1 hour of individual therapy and 1.5 hours of skills training groups per week.

The focus is on a therapeutic alliance in which skills (motivation and capability enhancement on the part of both patient and therapist) are taught and reinforced, and undesirable behaviors are decreased through contingency management. Skills training provides psychoeducation in 4 areas: distress tolerance, emotional regulation, interpersonal effectiveness, and mindfulness. The patient uses the learned skills to resolve problems with emotional dysregulation, impulsivity, and interpersonal instability. The dialectic approach involves balancing behavioral change with validation and acceptance of the patient's experience. Therapists meet weekly in a consultation group to receive support in maintaining a validating and dialectic stance toward their patients.

A landmark study by Linehan and colleagues⁸ garnered a great deal of attention because it provided the only data of its kind at the time. Compared with patients who received treatment as usual, patients treated with dialectical behavior therapy dropped out of treatment less often ($z = 3.59$; $P < .001$) and had significant reductions in the number and severity of suicide attempts ($z = 2.69$; $P < .01$, 1-tailed test) and in the duration of inpatient stays ($z = 1.70$; $P < .05$). Subsequent studies also found dialectical behavior therapy efficacious for BPD.⁹⁻¹¹

Despite these encouraging outcomes, there was a significant limitation to studies of dialectical behavior therapy—samples sizes were small and comparisons were made against control groups in which the patients received less treatment in a less credible therapy than the patients who received dialectical behavior therapy. In addition, studies of drug-dependent and opioid-dependent women with BPD had mixed results.

To test dialectical behavior therapy against a more stringent control, Linehan and colleagues⁹ compared 100 patients treated with dialectical behavior therapy with patients treated by therapists who were nominated by heads of community agencies as experts in working with "difficult clients." Patients treated in the latter group were designated as having received "community treatment by experts" (CTBE). Among recipients of dialectical behavior therapy, there was significantly less dropout than among recipients of CTBE (19.2% v 46.9%, respectively; hazard ratio, 3.2; $P < .001$). There were few other differences in the intent-to-treat (ITT) analyses. Although patients who received dialectical behavior therapy were half as likely to make a suicide at-

tempt as those who received CTBE when analyzed with the treatment year and follow-up period combined, the difference disappeared when only the follow-up period was examined.

The seriousness of suicide attempts differed between the two groups in the ITT analysis; however, there were no differences in emergency department use, hospitalization, parasuicidal attempts, medication use, global functioning, social adjustment, and anger. With regard to dose-controlled effects, completer analyses found no differences.¹² At follow-up 1 year after the completion of the study, there were also no differences between the dialectical behavior therapy and CTBE groups on any of the variables.

McMain and colleagues¹³ compared dialectical behavior therapy with general psychiatric management as articulated in the APA Treatment Guidelines. On the basis of the APA Guideline's focus on the centrality of psychosocial treatments, in this study individual psychodynamic psychotherapy (based on Gunderson's¹⁴ model of treatment) was combined with pharmacotherapy and case management. Results with general psychiatric management plus individual psychodynamic psychotherapy were equal to those with dialectical behavior therapy. Although outcomes for patients who received dialectical behavior therapy were comparable to outcomes for patients in previous studies, there were no between-condition differences in rates of change for suicidality, self-injury, psychiatric service use, BPD symptoms, depression, anger, and social functioning. These findings held up after 1-year follow-up.

Schema-focused therapy. This twice-weekly individual therapy is an integrative approach that "draws on insights and techniques from the cognitive-behavioral, attachment, psychodynamic, and emotion-focused traditions."^{3,15} The schemas in question are internal representations of self in relation to others but do not include a sense of the dynamic unconscious. Rather, patients are helped to identify their schemas without a focus on understanding the motivations that keep them outside of awareness. The 4 core mechanisms used in schema-focused therapy are (1) limited reparenting, (2) experiential imagery and dialogue work, (3) cognitive restructuring and education, and (4) behavioral pattern breaking.

Limited reparenting has been described as at the heart of schema-focused therapy. It is based on the assumption that BPD patients' core emotional needs were not met by their parents or that the parents overtly traumatized the patient and that the therapist should provide the experience of having basic emotional needs met by offering himself or herself as a parental figure. Thus, limited reparenting welcomes and encourages dependency on the therapist and ranges from providing warmth, nurturance, and occasional hugs to self-disclosure, firmness, and limit setting.

The goal is the internalization of the therapist as a healthy parent through these re-parenting experiences, emotion-focused work, cognitive restructuring, and breaking behavioral patterns. Schema-focused therapy uses experiential techniques, such as imagery, role-playing, and letter writing, and behavioral techniques, such as relaxation, assertiveness training, anger management,

and gradual exposure to anxiety-provoking situations. The therapy also challenges negative thoughts and beliefs about oneself through cognitive techniques and behavioral experiments while using the therapy relationship to improve the capacity to attach to others.

Giesen-Bloo and colleagues¹⁶ compared schema-focused therapy with transference-focused psychotherapy provided over 3 years. They found that patients benefited from both treatments, but significantly larger effects favoring schema-focused therapy emerged by year 3 in reduced self-reported BPD symptoms (MSTS = 9.81; $P < .001$), improved self-reported quality of life (MSTS = 6.09; $P = .001$), and less distress on a single factor measure of personality functioning (MSTS = -6.73; $P < .001$). Furthermore, the transference-focused psychotherapy group had a significantly higher dropout rate over the 3 years of treatment ($P = .01$). However, completer analyses did not show any statistically significant advantage for schema-focused therapy. A second RCT compared schema-focused therapy with telephone consultation with schema-focused therapy without telephone consultation and did not find any group differences.¹⁷ Although there are a number of limitations in the Giesen-Bloo study, schema-focused therapy nonetheless may be an effective treatment for BPD.

Other cognitive and behavioral approaches. Although not as well studied, there are other modified cognitive and behavioral approaches that have begun to show efficacy as treatments for BPD. For example, Systems Training for Emotional Predictability and Problem Solving (STEPPS) is a manualized adjunctive group treatment for patients with BPD that integrates cognitive-behavioral and group systems interventions.¹⁸ STEPPS conceptualizes BPD as an "emotional intensity disorder" for which specialized skills are needed to monitor and manage intense affects.

BPD is understood in a systemic context in which others may be reinforcing pathological behavior. In an RCT of 124 patients with BPD, patients treated in STEPPS had greater reductions in BPD symptoms ($F_{1,89} = 11.0$; $P = .001$), impulsivity ($F_{1,89} = 6.9$; $P = .01$), emotionality ($F_{1,89} = 7.6$; $P = .007$), and global functioning ($F_{1,84} = 12.1$; $P < .001$) than patients who received treatment as usual.¹⁹ However, STEPPS was not found to be different from treatment as usual on key symptoms such as suicidal and self-injurious behaviors or hospitalizations. Nonetheless, these findings suggest that this promising approach should be evaluated further, using a more stringent comparison group.

Of note: all the evidence-based treatments represent modifications of standard CBT and in fact tend to be integrative. Linehan and Young were both explicit about developing their modified and integrative treatments because of their experience that standard CBT was not effective for BPD. Data suggest that they were correct in this inference. In the Borderline Personality Disorder Study of Cognitive Therapy (BOSCOT) trial, there were no differences between CBT and treatment as usual on any of the primary outcome

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measures and on most secondary outcome measures.²⁰ Distress and dysfunction remained high even after 2 years of treatment, which suggests that standard CBT is contraindicated for patients who suffer from BPD.

Psychodynamic therapies

Psychodynamic therapies have also been modified for treatment of patients with BPD. Three manualized psychodynamic treatments have shown efficacy for BPD: mentalization-based therapy, transference-focused psychotherapy, and dynamic deconstructive therapy. In addition, 2 nonmanualized psychodynamic treatments have shown efficacy. Individual psychodynamic psychotherapy, based on Gunderson's¹⁴ model in combination with general psychiatric management, was efficacious in a comparison with dialectical behavior therapy.¹³ Supportive dynamic psychotherapy was efficacious in a trial with transference-focused psychotherapy and dialectical behavior therapy.²¹

These modified approaches share many core psychodynamic principles, including a concern with helping each individual find a balance among the forces that affect his or her feelings, thoughts, and behaviors. These forces include the biological urges (eg, love, hate, anxiety), internalized constraints against these urges (moral values), and the values and constraints of the individual's social context ("external reality").

Psychodynamic therapies help patients find a balance that allows them adequate satisfaction of their urges while maintaining adequate control to successfully adapt to the world. These therapies help the patient understand unconscious irrational patterns of thinking that may underlie behavioral symptoms. Treatments are based on the idea that once the patient becomes aware of these unconscious thoughts and feelings, he will be able to master aspects of himself that had previously exerted unconscious control on his behavior.

The goal of treatments based on psychodynamic models is to help people integrate all aspects of their internal experience (eg, shameful or "unacceptable" thoughts, feelings, and motivations) to experience themselves and others in a more coherent, balanced way. In mentalization-based therapy, this is accomplished by helping the patient see alternative perspectives and appreciate the mental states of others.

In transference-focused psychotherapy the therapist helps the patient integrate these disparate psychological states using the transference relationship as a vehicle for understanding relational patterns that emerge outside of the patient's awareness. For example, the therapist may note subtle signs of anger under the guise of friendliness, or vice versa—this alerts the therapist to the patient's discomfort and the need to understand the reasons behind the discomfort.

Mentalization-based therapy. This therapy integrates attachment theory, philosophy (theory of mind), ego psychology, and select aspects of Kleinian theory.²² It posits that the mechanism of change in all effective treatments for BPD in-

volves the capacity to think about mental states in terms of wishes, desires, and intentions—mentalization. This involves inviting patients to become curious about their thoughts, beliefs, and especially manifest affects about themselves and others; a capacity that is challenged by the activation of the attachment system in affectively charged interpersonal situations.

Mentalization-based therapy sees the core problem in BPD as a deficit in the capacity to mentalize or reflect on internal experiences and mental states. Therapy focuses on improving the patient's capacity to think about intentions and motivations by increasing conscious awareness of previously inchoate affective states, thus promoting satisfying interpersonal relationships; heightened tolerance of distress; and reduction in impulsive, destructive behaviors.

Mentalization-based therapy can be conducted either in a day hospital setting that includes expressive individual therapy, group therapy, and a community meeting or in individual outpatient therapy. The therapist explores what is going on in the patient's mind that leads to his affective experience, as well as what the patient imagines is going on in the therapist's mind. The objectives of mentalization-based therapy are described as not "aiming to achieve structural or personality change or alter cognitions and schemas; its aim is to enhance embryonic capacities of mentalization so that the individual is more able to solve problems and to manage emotional states particularly with interpersonal relationships."^{23(p200)}

Bateman and Fonagy²⁴ compared the effectiveness of 18 months of a psychoanalytically oriented day hospital program with routine general psychiatric care for patients with BPD. Mentalization-based therapy statistically significantly improved depressive symptoms ($F_{1,33} = 13.1$; $P < .001$), social functioning ($F_{1,33} = 8.7$; $P < .006$), and interpersonal functioning ($F_{1,34} = 63.7$; $P < .001$). In addition, there were significant decreases in suicidal and parasuicidal behavior ($\chi^2(3) = 33.5$; $P < .001$) and number of days in inpatient treatment ($t_{36} = 13.23$; $P < .001$).

Follow-up results after 18 months indicate that patients who completed mentalization-based therapy not only maintained their substantial gains but also showed continued steady and statistically significant improvement on most measures.²⁵ The 8-year follow-up showed maintenance of treatment gains²⁶: 87% of patients treated no longer met criteria for BPD, compared to only 13% of those treated in routine general psychiatric care. Decreased suicidality, psychiatric service use, medication use, and improved vocational functioning were also maintained; however, social functioning remained impaired. Findings showing the long-term maintenance of treatment gains for BPD patients are important. However, these long-term follow-up data are based on comparison with a treatment-as-usual cohort; more research is needed to fully evaluate the long-term efficacy of this therapy.

More stringent control was provided in a later RCT.²⁷ The effectiveness of 18 months of outpatient mentalization-based therapy was compared with structured clinical management for patients with BPD. The findings show that while patients benefited from both treatments, larger ef-

fect sizes were reported in mentalization-based therapy than in structured clinical management for reduced suicidal and self-harm behavior and number and length of inpatient hospitalizations ($\chi^2(1) = 4.3$; $P < .04$), as well as statistically significant improvement in depressive symptoms ($\chi^2(3) = 394.37$; $P < .001$) and better social ($\chi^2(3) = 327.00$; $P < .001$) and interpersonal functioning ($\chi^2(3) = 203.35$; $P < .001$).

The data from these studies show that mentalization-based therapy is effective. To build an empirically grounded framework for this psychotherapy, the next step in the hierarchy of treatment evidence would be to compare mentalization-based therapy with a well-established, well-delivered alternative treatment (such as dialectical behavior therapy, transference-focused psychotherapy, or schema-focused therapy).

Transference-focused psychotherapy. In addition to helping improve mentalizing, transference-focused psychotherapy focuses on conflicts among different internal states and helps the patient resolve conflicts and establish an inner balance.⁵ The therapy is based on the concept of a fundamental split within the patient's mind that sequesters affect states into separate all-negative and all-positive segments.

The extreme affect states are connected to images of self and other. Trigger events activate these internal images that are projected onto the current situation. Any affect that the patient experiences is thought to have a connection to the patient's experience of a relationship, including the relationship with the therapist. Therapy is based on the ideas that the raw affect can be transformed into words and can be explored to see whether the extreme feeling in the moment corresponds to the reality of the relationship or whether it represents an exaggerated, partial, or distorted experience.

In this twice-weekly therapy, symptomatic change in transference-focused psychotherapy is believed to be accomplished first through limit-setting (eg, the treatment frame) and then more deeply through the development of integrated representations of self and others, leading to a full and coherent sense of self. The analysis of the relationship with the therapist (the transference) is the primary vehicle for this work. The goal is not just changing symptoms but changing the personality organization—the split mental structure—that is the basis of the specific symptoms of the disorder.

In transference-focused psychotherapy, as affects are experienced in sessions, the engaged, interactive, and emotionally attentive stance of the therapist is typically experienced by patients as emotionally holding (containing) because the therapist conveys that he can tolerate the patient's negative affective states without denying them or reacting in a retaliatory way. The process of clarification helps the patient mentalize internal states. Then confrontation (identifying elements of the patient's verbal and nonverbal communications that are in contradiction with each other) and interpretation of aspects of the patient's experience that are split increase the ability to integrate the different parts, a process that improves affect tolerance and impulse control.

Efficacy was shown in 2 RCTs that compared outcomes for patients who received transference-

focused psychotherapy (TFP) with outcomes for active controls.²⁸⁻³⁰ In the first study, transference-focused psychotherapy was compared with dialectical-behavior therapy (DBT) and a psychodynamic supportive psychotherapy (SPT).²¹ Study data show that all 3 groups had significant improvement in both global functioning (TFP, $P = .001$; DBT, $P = .004$; SPT, $P = .001$) and social functioning (TFP, $P = .03$; DBT, $P = .001$; SPT, $P = .001$), and significant decreases in depression (TFP, $P = .001$; DBT, $P = .003$; SPT, $P = .001$) and anxiety (TFP, $P = .004$; DBT, $P = .001$; SPT, $P = .001$). Significant improvements were seen in suicidality with transference-focused psychotherapy and dialectical behavior therapy (TFP, $P = .01$; DBT, $P = .01$) but not with supportive psychotherapy. Transference-focused psychotherapy and supportive psychotherapy provided significant improvements in anger (TFP, $P = .001$; SPT, $P = .05$), but dialectical behavior therapy did not. Only transference-focused psychotherapy demonstrated significant improvements in verbal assault ($P = .001$), direct assault ($P = .05$), and irritability ($P = .01$).²⁸

Levy and colleagues²⁹ examined changes in attachment organization and reflective function as putative mechanisms of change. After 12 months of treatment, there was a significant increase in the number of patients classified as secure with respect to attachment state of mind for transference-focused psychotherapy ($\chi^2(1) = 4.17$; $P < .04$) but not for the other two treatments. Significant changes in narrative coherence ($F_{3,54} = 6.28$; $P < .05$) and reflective function ($F_{3,54} = 15.05$; $P < .05$) were found as a function of treatment. There were increases in both constructs during the course of treatment with transference-focused psychotherapy but not with dialectical behavior therapy and supportive psychotherapy. These findings are notable because they suggest not only that transference-focused psychotherapy works in a theoretically predicted way, but also that the benefits of this treatment go beyond symptom reduction to address broader issues of the patient's sense of self and relatedness to others.

Although there were no differences in outcome between dialectical behavior therapy and transference-focused psychotherapy, the study was not formally powered to test equivalence and therefore findings cannot technically be interpreted as such. However, transference-focused psychotherapy was found to be uniquely related to changes in attachment and mentalizing capacity during the course of treatment.

Doering and colleagues³⁰ compared 1 year of transference-focused psychotherapy with treatment by experienced community psychotherapists. While patients improved with both treatments, patients randomly assigned to transference-focused psychotherapy showed significantly better outcomes as evidenced by lower dropout rates (38.5% vs 67.3%; $\chi^2(1)$; $P = .003$); significantly greater reductions in the number of attempted suicides ($\chi^2(1) = 13.09$; $P = .001$), number of inpatient admissions ($F_{1,99} = 8.814$; $P = .004$), and BPD symptoms ($\chi^2(1) = 3.961$; $P = .047$); and significantly greater improvements in personality organization ($F_{1,69} = 4.765$; $P = .03$) and psychosocial functioning ($F_{1,69} = 6.420$; $P = .02$).

In both groups, there were significant improvements in depression ($t_{50} = 3.151$; $P = .003$) and anxiety (state anxiety, $t_{51} = 2.388$; $P = .02$; trait anxiety, $t_{51} = 3.116$; $P = .02$). General psychopathology also improved in the transference-focused psychotherapy group ($t_{51} = 2.265$; $P = .03$), all without significant group differences ($P > .05$). Self-harming behavior decreased but did not change significantly in either group. The strengths of this study include the reporting of both ITT and completer analyses as well as using well-trained therapists committed to treating BPD patients in both treatment cells. One limitation in this study is that those in the transference-focused psychotherapy group received significantly more psychotherapy sessions than those treated by experienced community psychotherapists (2:1 for completers; 3:1 for ITT).

One other general issue regarding transference-focused psychotherapy is that it appears to require more intensive training than some of the other treatments discussed. For example, typically nurses in the British National Health Service are the mentalization-based therapists (it is unclear how easy or difficult it is to train therapists to adherence in dialectical behavior therapy). However, it is important to note that the aims of mentalization-based therapy are admittedly more modest than those of transference-focused psychotherapy in that it is not "aiming to achieve structural or personality change or alter cognitions and schemas."^{23(p200)}

Other psychodynamic approaches. A number of other psychodynamic approaches may be found to be effective BPD treatments with additional research. For example, an interpersonal-self psychological approach was compared with treatment as usual: 30% of the patients with BPD who were treated with interpersonal-self psychology twice weekly for 1 year no longer met criteria for BPD at the end of the treatment year, whereas all of the treatment-as-usual patients still met criteria for the diagnosis.^{31,32} Improvements were maintained at the 5-year follow-up; 40% of the patients no longer met criteria for BPD, spent less time in the hospital (although no decrease in number of hospitalizations), and had an increase in time employed.³³

A recently completed second study of similar design replicated these findings, although the inferences that can be drawn from these studies are limited by the lack of a randomized control group.³⁴ Clearly, the findings from these studies suggest the promise of the approach and call for the more stringent testing in an RCT.

General psychiatric management is an evidence-based practice approach that incorporates individual psychodynamic psychotherapy for patients with BPD.^{1,14,35} General psychiatric management was recently evaluated by McMMain and colleagues¹³ in an RCT with dialectical behavior therapy, and the treatments were found to perform equally well. There were no between-condition differences in rates of change across 1 year of treatment for suicidality, self-injury, psychiatric service use, BPD symptoms, depression, anger, and social functioning.

This study was not intended to be powered as an equivalence study. Furthermore, individual psychodynamic psychotherapy's efficacy within

the general psychiatric management model would need to be replicated in further RCTs. However, this study is suggestive of the value of Gunderson and Links³⁵ approach to treating patients with BPD.

Dynamic deconstructive psychotherapy has shown efficacy for comorbid BPD and substance use disorders, which is a common but severe and refractory subgroup.⁶

In a 12-month RCT with 30-month follow-up, dynamic deconstructive psychotherapy was compared with optimized community care—a high-intensity community treatment. Dynamic deconstructive psychotherapy resulted in significant improvements in suicide attempts and self-harm ($S = 18$; $P = .008$), heavy drinking ($S = 22$; $P = .008$ [P values not reported for within group differences]), drug use, and multiple measures of psychopathology, including depression ($F_{1,10} = 13.43$; $P = .004$ [P values not reported for within group differences]), dissociation, BPD symptoms ($F_{1,10} = 13.43$; $P = .004$), and perceived social support ($S = 26$; $P = .021$).³⁶ Therapists' adherence to dynamic deconstructive psychotherapy techniques was highly correlated with outcome, which suggests that the putative mechanisms of the treatment were responsible for the improvements. Findings were maintained at an 18-month follow-up. These findings are promising but are hampered by a small sample size.

As for supportive psychotherapies, 3 RCTs examined modified dynamic supportive psychotherapies: one compared it with transference-focused psychotherapy and dialectical behavior therapy, another compared it with dialectical behavior therapy, and the third compared it with mentalization-based therapy. In each case, supportive psychotherapy compared well with other treatments. It is important, however, to stress that these supportive psychotherapies were not typical as carried out in the community. Instead, they were all modified to be specific with BPD. In addition, in each study, the therapists who provided supportive psychotherapy were experienced in treating BPD, and they were being supervised. In some cases, the supportive psychotherapies also included booster sessions. Nonetheless, these modified and supervised intensive supportive psychotherapies have done remarkably well and deserve further consideration and study.

Conclusions

While many different treatments have shown efficacy in comparison with "treatment as usual" or to a more stringent comparison group of "experts in the community," comparisons between well-delivered bonafide treatments generally find few reliable differences. Thus, there is no evidence to suggest that any of these empirically supported treatments is the "treatment of choice" for BPD.

It is highly unlikely that any given treatment would ever be identified as "one size fits all" treatment for BPD, given the heterogeneity of the disorder. Rather, future research and clinical refinement of therapies for BPD should focus on the mechanisms within each treatment that are most associated with improvement, and on patient and therapy variables that could help guide

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the patient to the specific treatment that would be most helpful at that point in his trajectory of illness. Only then will we be able to better determine “what treatment, by whom, is most effective with this individual, with that specific problem, under which set of circumstances?”³⁷ (p11)

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1. Which of the following is founded on modified cognitive-behavioral therapy principles?
 - A. Transference-focused psychotherapy
 - B. Mentalization-based therapy
 - C. Schema-focused therapy
2. Which of the following is an effective treatment for borderline personality disorder (BPD) as evidenced by randomized clinical trials?
 - A. Dialectical behavior therapy
 - B. Mentalization-based therapy
 - C. Transference-focused psychotherapy
 - D. All of the above
3. Which of the following therapies provides skills training in distress tolerance, emotional regulation, interpersonal effectiveness, and mindfulness?
 - A. Mentalization-based therapy
 - B. Dialectical behavior therapy
 - C. Schema-focused therapy
4. Limited reparenting, experiential imagery and dialogue work, cognitive restructuring and education, and behavioral pattern breaking are the cornerstones of which therapy?
 - A. Schema-focused therapy
 - B. Mentalization-based therapy
 - C. Supportive dynamic psychotherapy
5. The dialectic approach involves balancing behavioral change with validation and acceptance of the individual's experience.
 - A. True
 - B. False
6. Which of the following statements is true about transference-focused therapy?
 - A. It emphasizes “reparenting” to compensate for traumatic experiences in the patient's history.
 - B. It addresses deficits in skills.
 - C. The goal of treatment is to achieve a coherent sense of self.
7. All efficacious treatments for BPD include which of the following qualities?
 - A. A clear treatment frame
 - B. A clear conceptual framework
 - C. A peer consultation/supervision group
 - D. All of the above
8. Which of the following therapies has shown promise in treating comorbid BPD and substance use disorders?
 - A. Dynamic deconstructive psychotherapy
 - B. General psychiatric management
 - C. The interpersonal-self psychological approach
 - D. None of the above
9. Which of the following is true of mentalization-based therapy?
 - A. It can be provided only as a day hospital treatment.
 - B. It showed continued patient improvement in study follow-up data.
 - C. Its goal is to achieve structural or personality change.
10. Future research on BPD treatments should focus on which of the following?
 - A. Mechanisms within each treatment that are most associated with improvement
 - B. Patient variables that could help guide treatment choice
 - C. Therapy variables that would most benefit patients
 - D. All of the above