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Crossing the Alphabet Divide

Navigating the Evidence for DBT, GPM, MBT, ST, and TFP for BPD

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Key Points

- Borderline personality disorder (BPD) is prevalent, complex, and historically difficult to treat.
- A number of treatments—primarily from cognitive-behavioral and psychodynamic traditions—have been developed and show efficacy in treating BPD.
- The "Big Five" empirically supported treatments for BPD are: dialectical behavior therapy (DBT); mentalization-based therapy (MBT); transference-focused psychotherapy (TFP); schema therapy (ST); and good psychiatric management (GPM).
- DBT is a behavioral, skills-focused treatment that targets self-harm and other behavioral manifestations of emotion dysregulation.
- MBT aims to improve clients' capacity to mentalize: to think about mental states in oneself and others.
- TFP addresses unintegrated internal representations of self and others to make more coherent clients' identity and foster enhanced self-regulation.
- ST aims to alter maladaptive schemas that generate and maintain dysfunctional views of oneself and others.
- GPM targets interpersonal sensitivity in BPD and is designed as a generalist treatment available to all manner of practitioners, rather than the specialist treatments DBT, MBT, TFP, and ST.
- The evidence for treating BPD as captured in randomized controlled trials (RCTs) and meta-analyses is strong and growing.
- RCTs have been conducted finding support for DBT, MBT, TFP, ST, and GPM.
- At least 14 RCTs have been conducted on DBT, finding significant reduction in behavioral symptoms of BPD, such as self-harm and suicide in particular.
- Two large-scale and four smaller RCTs have been conducted on MBT, finding significant improvement in social and interpersonal functioning in BPD, as well as other related symptoms.
- Three RCTs have been conducted on TFP, finding improvement in a range of primary and secondary features of BPD, particularly reflective functioning and attachment security.

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- Three RCTs conducted on ST have found improvement in diagnostic criteria for BPD and improvement in quality of life.
- One original RCT of GPM, with two-year follow-up, suggests improvements in self-harm, hospitalizations, BPD symptoms, and secondary features, though examinations of the current standalone treatment have yet to be conducted.
- A number of meta-analyses of BPD treatments of various formats (e.g., individual, group) suggest treatments are moderately effective, no treatment modality claims superiority, and that psychotherapy—rather than medication management—is the optimal treatment approach for BPD.
- Treatments for BPD are generally long-term, intensive, and often include multiple formats (e.g., individual plus group).
- Therapists treating BPD generally require peer support/supervision and specialized training.
- BPD treatment is generally active, integrative, collaborative, flexible, and focused on emotion regulation and views of self and/or other.
- Given that a range of efficacious treatments exist, but without a clear "gold standard," we propose a number of integrative principles that cut across interventions.
- More research is needed to empirically evaluate how best to sequence or combine treatments and their elements.

Introduction

Borderline personality disorder (BPD) is a complex psychological disorder and one of the most vexing problems to treat in psychology and psychiatry. Historically, BPD has been thought to be difficult to treat because patients frequently do not adhere to treatment recommendations, use services chaotically, and repeatedly drop out of treatment. Many of the core difficulties associated with BPD—such as the chaotic relationships, vacillations between idealizations and derogations, tendency toward angry outbursts, and of course the suicidality and non-suicidal self-injury with its unpredictability—present special challenges to the therapist working with such patients. Individuals with BPD often present with extreme dependence, hostility, or confusing vacillations, and experience frequent, sometimes even "unrelenting" crises.[1] Clinicians are often intimidated by the prospect of treating BPD patients and are pessimistic about the outcome of treatment. Additionally, in settings with multiple care providers, patients with BPD may tend to split providers into idealized and devalued groups, which, if not well-managed, can impact the treatment team's ability to collaborate effectively.[2,3] Consequently, 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.[4,5]

However, over the last decade there has been a burgeoning empirical literature on the treatment of BPD suggesting that it can indeed be treated. Beginning with Linehan's seminal randomized controlled trial (RCT) of dialectical behavior therapy (DBT),[1] there are now a range of treatments—deriving from both the cognitive-behavioral and psychodynamic traditions—that have shown efficacy in RCTs and are available to clinicians. Among the available treatments for BPD are DBT, as well as mentalization-based

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treatment (MBT)[6]; transference-focused psychotherapy (TFP)[7]; schema therapy (ST),[8] and good psychiatric management (GPM).[9] These treatments have been referred to as the "Big Five."[10] In addition to the Big Five, there are several other treatments available to clinicians, including dynamic deconstructive psychotherapy (DDP)[11]; Systems Training for Emotional Predictability and Problem Solving (STEPPS)[12]; emotion regulation group therapy (ERGT)[13]; motive-oriented therapeutic relationship (MOTR)[14]; structured clinical management (CM),[15] and stepped care management (SC).[16] Adding to the expansive list of available treatments of BPD, there has also been one RCT of manual assisted cognitive treatment (MACT),[17] a highly structured adaptation of cognitive behavioral therapy (CBT), which has shown benefit for self-harm but has not been evaluated for other BPD symptoms.[18] Other approaches include psychoeducation.[19]

The results of the efficacy studies suggest several important evidence-based principles. First, BPD is a treatable disorder, although with specifically defined treatments. Second, therapists have a range of treatment options available to them. These options cut across psychodynamic and cognitive-behavioral theoretical orientations. Additionally, there is now enough data from numerous RCTs, including a few direct comparisons, and from several meta-analyses to suggest that no one approach is superior to another.[20–22] These findings suggest two corollary ideas. First, despite often espousing very different perspectives, there may be common factors that cut across the various approaches[23] (see Chapter 6, The Big Six: Evidenced-based Therapies for the Treatment of Personality Disorders, for additional discussion). Second, there may be many "roads to Rome," that is, multiple distinct treatments for BPD may be equally effective in producing desired outcomes.[23,24] However, in part due to the findings suggesting equivalence of outcomes, clinicians are left with a high degree of uncertainty about treatment selection, determining which patients will benefit from which specific or range of treatments, and how best to sequence or combine treatments and their elements.

The primary goal of this chapter is to summarize evidence for the various treatments for BPD, provide an overarching perspective by integrating findings from RCTs and meta-analyses to derive principles for treatment, and discuss strategies for integrating various approaches. Because of the many acronyms employed for the various treatments for BPD (e.g., DBT, MBT, TFP), we refer to the problem of treatment selection, derivation of principles, and psychotherapy integration as navigating or crossing the "alphabet divide." In this spirit, we encourage clinical researchers to begin examining treatments more broadly, including how elements of various approaches may be combined or sequenced to better help patients. We hope that the approach taken in this chapter and in Chapter 6 is helpful to patients and their families in seeking services, and that it may impact policymakers and insurance companies to consider a more complete evidence base.

The importance of thinking and treating across the alphabet divide is underscored not only by the findings of equivalent effects among different treatments, but also because even though many patients improve in these treatments, many others do not. Additionally, many patients who *do* show symptomatic improvement and even diagnostic remission still experience significant social and functional impairment over the long term. Both those who fail to improve and those who show partial or limited improvement may benefit and be better served from the inclusion of elements from other treatment approaches across the alphabet divide.[25] Finally, given the heterogeneity of BPD, it is unlikely that any one treatment will be useful for all patients, and thus having different treatment options is essential to clinicians in providing personalized care.

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Evolution and Characterization of Treatments for BPD

DBT, MBT, TFP, ST, and GPM are referred to as the Big Five because they are theory-based, comprehensive approaches that have been broadly tested and well-disseminated. DBT, MBT, TFP, and ST are considered specialized treatments because they are adapted or modified from broader psychotherapy traditions such as CBT or psychodynamic psychotherapy (PDT), based on the specific psychopathology believed to underlie BPD. In doing so, Marsha Linehan[1,26] and Otto Kernberg,[3,27] from their respective traditions, were prescient of Kazdin's[28,29] later recommendations that treatment approaches should be based on the underlying developmental psychopathology of the problem being addressed. Thus, rather than a "one size fits all" philosophy, these clinical scholars followed a "different strokes for different folks" approach.[30] Jeff Young and Peter Fonagy employed the same philosophy in developing ST and MBT, respectively. Although Fonagy shares in many of the same psychodynamic theoretical bases as Kernberg (e.g., the importance of object relations, Kleinian theory, and ego psychology), he deviated from Kernberg in several important ways, some of which were consistent with the emphasis of Kohut[31] and Adler and Buie,[32,33] and others in ways that are based on his own articulation within psychoanalysis.[34] Young, a student of Aaron Beck, adapted cognitive therapy for patients suffering from BPD in developing ST. Coming from the Beckian tradition, his model is more cognitive in its focus compared to Linehan, which stressed more behavioral aspects. Each of these approaches is also considered specialized because, in addition to being developed specifically for BPD (or personality disorders more broadly), these treatments are intensive and, in addition to having a substantial commitment to treating this population of patients, are conducted by specially trained clinicians who need to devote many hours over several years toward developing adherence and competence in complex models. Often these treatments occur within specialized clinics or programs and are carried out by certified therapists.

In contrast, Gunderson's GPM is considered a generalist approach because it is rolled out more broadly to hospital and clinic staff and represents a distillation and application of the American Psychiatric Association's Practice Guidelines for the treatment of BPD.[35] It is an approach that is meant to be disseminated broadly to staff to guide interactions with patients suffering from BPD, and it is meant for those patients who may not require or do not have specialized treatments such as DBT, MBT, TFP, and ST available to them. Gunderson and colleagues[36] note that there are not enough treaters trained in the time-consuming specialized treatments for BPD and, similar to Paris,[16,37] suggest that not every BPD patient is in need of or can utilize a specialized treatment.

We will provide more specific, although brief, reviews of each of the Big Five treatments, including both the conceptual foundations of each treatment and the existing state of the literature on treatment efficacy. A complete consideration of the adjunctive treatments and generalists approaches beyond GPM is beyond the scope of this chapter.

Dialectical Behavioral Therapy (DBT)

DBT was initially developed in the 1980s by Marsha Linehan as a treatment program for women with parasuicidal and suicidal behaviors.[26] It was while applying for funding that program officers at NIMH suggested to Linehan that she had actually developed a treatment for BPD (Irene Elkin, Ph.D., conversation, June 20, 2007). These program

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officers suggested that she develop expertise in BPD. After a sabbatical semester at Cornell working with Otto Kernberg and John Clarkin, Linehan completed her treatment manual[1] and tested her treatment in a sample of women with BPD.[38] Although DBT is admittedly integrative[39] and shares aspects with even divergent approaches such as TFP,[40] it evolved out of a behavioral tradition (hence the initial focus on behaviors like parasuicidal and suicidal attempts) with integration of modified CBT skills modules and Buddhist philosophies. Linehan recognized that traditional CBT skills were not as relevant to the difficulties seen in BPD that led to self-injury and suicidality, and identified behavioral techniques and skills training to alleviate behavioral manifestations of emotion dysregulation in BPD as well as improve interpersonal functioning.[1,26] The focus of DBT lies in replacing maladaptive behaviors such as self-harm with adaptive skills, emphasizing a balance between change-focused techniques (e.g., cognitive modification) and acceptance-focused practices (e.g., mindfulness training).[41,42] See Chapter 11 for a broad discussion of DBT.

Mentalization-based Treatment (MBT)

Bateman and Fonagy[43] developed MBT based on the developmental theory of mentalizing, which integrates philosophy (theory of mind), ego psychology, Kleinian theory, and attachment theory.[34,44–47] Fonagy and Bateman's[48] MBT posits that the mechanism of change in all effective treatments for BPD involves the capacity for mentalizing—the capacity to think about mental states in oneself and in others in terms of wishes, desires, and intentions. Mentalizing involves both (1) implicit or unconscious mental processes that are activated along with the attachment system in affectively charged interpersonal situations, and (2) coherent integrated representations of mental states of self and others. 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 might otherwise be lost."[22] 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.

MBT involves a collaborative and structured approach to working to gently expand mentalizing and helping clients to identify mental states that were previously outside of their 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 their 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 that are specifically defined in terms of technical application. As mentalizing improves, the client becomes increasingly able to generate 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

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strategies activated in relationships are mapped out with the client and a joint formulation agreed. A long-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 including 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. See Chapter 9 for a broad discussion of MBT.

Transference-focused Psychotherapy (TFP)

TFP is a modified psychodynamic psychotherapy designed for use with patients suffering from severe personality disorders, most prototypically borderline and narcissistic personality disorders.[49,50] Otto Kernberg, based on his experiences with the Menninger Psychotherapy Research Project, began modifying standard psychodynamic psychotherapy. Initially, he referred to this therapy as "exploratory psychotherapy," in an effort to distinguish it from more supportive psychotherapies.[50] These modifications were based on Kernberg's articulation of the developmental psychopathology underlying severe personality disorders and the clinical realities of treating those with these disorders. Over the subsequent decades, Kernberg and colleagues, particularly Frank Yeomans and John Clarkin at the Personality Disorders Institute of Cornell University, further articulated and developed the treatment in a series of treatment manuals.[7,51]

The overarching goals of TFP are to improve self-control, reduce impulsivity, increase emotion-regulation abilities, increase intimacy in relationships and relationship satisfaction, and improve capacity to realize life goals (that are consistent with the patient's abilities and desires). More specific goals include improvements in the symptoms central to BPD, especially suicidal and parasuicidal behaviors, angry outbursts, and impulsive behavioral difficulties. Improvements in these areas are hypothesized to lead to reduction of emergency service use, hospitalizations, and difficulties in relationship. These changes are posited to follow from the integration of disparate, contradictory, and incoherent internal mental representations of self and others.

Fundamental to the TFP model is that BPD derives from a failure to develop internal representations of self and others that are complex and realistic and characteristic of healthy psychological maturation. These fragmented representations of self and others impede the person's capacity to reflect on interactions with others as well as their own beliefs and to behave in a thoughtful and consistent goal-directed manner. Additionally, this lack of integration leads to fluctuations between extreme positive or negative emotions that impairs an individual's perception of day-to-day interactions. The inconsistent sense of self and others is called "identity diffusion" in the TFP model, and is analogous to identity disturbance defined in DSM-5[52] as well as psychological processes regarding identity formation described by Blatt and Blass,[53] Erikson,[54] Marcia,[55] and McAdams.[56]

In the TFP model, identity diffusion is considered the source for emotion dysregulation seen in BPD. Thus, the treatment focuses on the integration of one's sense of self and others and the emotions linking them. This integration is hypothesized to lead to representational and affective experiences becoming more nuanced, enriched, and

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modulated. The increased differentiation and integration of these internal representations result in the patient developing the capacity to think more flexibly and positively about the therapist, significant others, and themselves. The integration of these internal representations is achieved by exploring and understanding the patient's contradictory experiences of self and others, but particularly of the therapist.

TFP begins with a thorough assessment called a structural interview.[57] Based on the information gathered during this process as well as from collateral sources (e.g., referrals, significant others, previous treaters), the therapist forms their initial diagnostic impressions of the patient's difficulties that will be shared with them. Therapists do not want to impose their impressions on the patient or for the patient to acquiesce to their point of view. Likewise, the therapist does not want to abandon their own point of view. Instead, the initial work often involves the patient and therapist collaboratively developing a shared view or understanding of the nature of the patient's difficulties. With a shared understanding of the patient's difficulties, the therapist and patient discuss the structure of the treatment; essentially, how the treatment is thought to work and what each party's roles and responsibilities are in it. Expected obstacles and threats to the treatment are raised and discussed, as are how emergencies and crises will be handled by the patient and therapist.

Once the evaluation and frame of the therapy are established, the treatment can start. In the beginning, the patient may test the treatment frame to see if the therapist is trustworthy. In session, the therapist attends to or focuses on the dominant affect to guide their attention. The therapist then listens for relational themes in the patient's narrative, which are called object relation dyads. These themes are conceptualized as relational dyads because there is a representation of the self and the other in the patterns expressed (as well as the self in relation to the other and the affect that connects these representational dyads). These representations of self and others tend to vacillate in patients with BPD. Initially the patient might see themselves as the victim of a cold, uncaring other, but then in the narrative they might portray themselves as uninterested and unaffected by the other, who may be seen as needy or desperate. The therapist articulates these dyads, notes their vacillation, and works with the patient to understand their function or underlying motives. In the process of doing so, the therapist clarifies the patient's experience, gently brings disparate aspects of the patient's experience into their awareness, and tactfully interprets the patient's dominant affect-laden themes as they are expressed in the here-and-now of the relationship between the two (conceptualized as transference). This interpretative process is hypothesized to integrate incoherent and polarized representations of the self and others, resulting in better affect regulation and behavioral control. See Chapter 8 for a broad discussion of TFP.

Schema Therapy (ST)

A fourth treatment modality with support for BPD is Young's schema-focused therapy, or schema therapy, developed in the early 1990s. ST draws from the domains of CBT, gestalt therapy, and psychodynamic theory in an attempt to alter maladaptive schemas formed early in development that generate and maintain dysfunctional views of oneself and others.[50,58,59] ST catalogues a number of primary "modes" or ways in which individuals with BPD may see themselves vis-à-vis others in a given moment or mental state (e.g., "abandoned and abused"), which tend to shift from moment to moment and

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contribute to the emotional and behavioral dysregulation characteristic of the disorder. ST uses a number of mode-specific interventions to increase the individual's awareness of being in a given mode, bring the therapist into the interpersonal space as a genuine, reliable, and supportive other, and reduce "flipping" between modes.[58] See Chapter 12 for a broad discussion of ST.

Good Psychiatric Management (GPM)

Gunderson with Links[9] developed what was originally called general psychiatric management, and is now named good psychiatric management. GPM was originally developed as an active and credible control condition for an RCT examining the efficacy of DBT[60] and was based on recommendations from the *Guidelines for the Treatment of BPD* published by the American Psychiatric Association in 2001.[35] Based on the APA treatment guidelines, GPM consisted of three modes of intervention, including (1) case management, (2) individual psychotherapy, and (3) symptom-targeted medication management. In the initial trial, therapist-provided psychotherapy was informed by John Gunderson's psychodynamic approach treating BPD.[61] GPM has evolved since the original trial, and what follows is a description of the treatment as it was evaluated in 2001.

In the GPM model, clients are viewed and treated as competent adults, and therapists are encouraged to be flexible in terms of the treatment focus. Much attention is accorded to the client's role functioning.[62] GPM conceptualizes disturbed attachment relationships in terms of interpersonal sensitivity[63] and intolerance of aloneness[64] as the core problem underlying BPD. Emotion-processing problems figure centrally in disturbed attachment relationships, and consequently GPM has an emotion focus.[65] There are a variety of treatment strategies in the model, including: responding to crises; safety monitoring; establishing and monitoring a therapeutic framework and alliance; educating the client and his/her family about the disorder; facilitating adherence to the treatment regimen; coordinating multimodal therapies; and monitoring clinical status and treatment plans. Ancillary treatments are tailored to the client's needs. 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. GPM incorporates aspects of a variety of therapy orientations, including interpretations of anger and acting out (PDT/TFP), psychoeducation, fostering social skills (CBT/DBT), and focusing on theory of mind and reflective functioning (MBT). What primarily sets GPM apart from these other treatments is that it does not claim to be a standalone specialized treatment for BPD but, with roots in Winnicott's[66] ideas of "good enough mothering," is instead designed as a "generalist" treatment, which can be implemented by all manner of practitioners, with more severe cases of BPD potentially being referred to "specialist" treatments such as TFP and DBT. See Chapter 13 for a broad discussion of GPM.

Evidence Base for Treatments

In this section, we consider the evidence base for the various treatments by reviewing the evidence from RCTs and meta-analyses.

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Randomized Controlled Trials for Treatment of BPD

Evidence for Dialectical Behavior Therapy for Treatment of BPD

To date, DBT is the most frequently studied treatment for BPD, with at least 14 RCTs having been conducted on the full DBT program in BPD-diagnosed samples. In general, when compared to treatment-as-usual (TAU), DBT has been shown to significantly reduce behavioral symptoms often present in BPD, including non-suicidal self-injury[67–72] and both suicide attempts and hospitalizations.[68,69] However, several studies have found no difference between DBT and TAU in behavioral symptom decrease,[60,73–75] suggesting that the efficacy of DBT for this symptom cluster has yet to be determined. Furthermore, comparison trials of DBT against other active treatments for BPD, such as TFP or GPM, have found generally comparable outcomes for these treatments.[60,76] There is some evidence to suggest that DBT may reduce dropout rates among patients with BPD, with at least three studies specifically finding lower rates of dropout compared to TAU or community treatment by experts.[68,72,77] DBT has shown moderate effect size in comparison with TAU,[78] but when compared to alternative treatments,[60,76,79,80] there is no difference in outcome or effect size.[20,78]

Unfortunately, given the focus on change in behavioral symptoms as outcome in DBT treatment studies, less is known regarding DBT's effectiveness in other BPD-relevant symptom domains, such as identity disturbance, emptiness, and relationship chaos. Some RCT evidence suggests that DBT may provide little benefit in terms of the identity-relevant construct of reflective functioning (i.e., one's capacity to reflect on the mental states of self and other) compared to TFP, a treatment that directly targets identity disturbance, another core feature of BPD.[76] A variety of quasi-experimental and uncontrolled studies have shown varying levels of support for DBT, but these tend to focus solely on TAU as comparison (if one is present), and the implications of these findings are therefore limited.

Evidence for Mentalization-based Treatment for Treatment of BPD

Bateman and Fonagy have conducted two large-scale RCTs of MBT supporting its use for BPD. In the first,[6] the effectiveness of 18 months of an MBT day-hospital program was compared with routine general psychiatric care for BPD patients. Patients randomly assigned to MBT showed statistically significant improvement in depressive symptoms and better social and interpersonal functioning, as well as significant decreases in suicidal and parasuicidal behavior and number of inpatient days. Follow-up assessment also showed that gains were maintained and increased remittance in the MBT condition compared to TAU.[81] The findings of this RCT were especially strong; however, the MBT treatment in this RCT occurred in a 30-hour-a-week comprehensive MBT day-hospital treatment, and the TAU group, although having had ecological validity, consisted of twice monthly medication management. Thus, the comparison between the two conditions differ quite a bit in terms of dose (30 hours a week compared to 2 hours a month).

The second RCT[82] compared 18 months of outpatient MBT with structured clinical management (SCM), which focused on problem-solving skills and providing support. The number of suicidal and parasuicidal events and hospitalizations decreased at a significantly greater rate by post-treatment follow-up among the MBT participants compared with those in the SCM condition. MBT participants also had greater declines in secondary symptom severity over 18 months of treatment, including depression, interpersonal function, social adjustment, and global assessment of functioning ratings.

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Furthermore, use of medication dropped significantly more in the MBT group than in the SCM group. While these findings provide support for MBT as an efficacious treatment for BPD, further follow-up analyses are needed to ascertain maintenance of treatment effects.

Evidence for Transference-focused Psychotherapy for Treatment of BPD

There is now accumulating evidence for the effectiveness and efficacy of TFP. At least three RCTs have examined the efficacy of TFP for BPD. The initial RCT by the Kernberg group[76,83] comparing TFP with two other active conditions (DBT and supportive psychotherapy [SPT][84]) found that TFP and DBT decreased suicidality over and above SPT; and TFP and SPT showed improvements in anger and impulsivity, whereas DBT did not. The TFP condition also showed unique improvements in a variety of aspects of aggression. The study further found roughly equivalent changes among the conditions in secondary features of depression, anxiety, and global level of functioning. In a second paper, this group[83] reported unique changes for TFP in comparison with DBT and SPT in reflective functioning (mentalizing) and attachment security. In sum, TFP appears at least as efficacious as DBT, but TFP may also provide unique and theoretically consistent improvements in areas such as attachment, identity, mentalizing, and aggression.

In a subsequent study by an independent group, Doering and colleagues[85] found that one year of TFP outperformed treatment provided by experienced community psychotherapists treating BPD, in terms of hospitalizations, suicide rates, BPD symptoms, psychosocial functioning, personality organization, secondary symptoms (e.g., anxiety and depression), and dropout rate. Although self-harm fell from 29.33 acts the year prior to 16.94 acts during the treatment year, this difference was not significant because of a large standard deviation, nor was it different from the reduction seen in the treatment by experienced community psychotherapists. TFP was also examined as a control condition in a study of ST.[86] Both treatments were quite effective at reducing the range of BPD symptoms and improving quality of life, yet the authors found that several BPD symptoms (e.g., impulsivity, fears of abandonment, relationship chaos) by year three of treatment improved more in ST over TFP. However, some concerns regarding the adequacy of the TFP implementation in this study[87,88] indicate that results may be unfairly partial toward ST, casting some doubt on the generalizability of the study in terms of TFP's efficacy for BPD.

Evidence for Schema Therapy for Treatment of BPD

Giesen-Bloo and colleagues[86] provide initial support for ST, as described in the discussion on TFP, although these results must be considered preliminary given the concerns we have outlined already. However, more recent data provide continued evidence for ST provided in a group format as an efficacious treatment for BPD. Farrell, Shaw, and Webber[89] report data from a small sample of women with BPD (N = 32), comparing eight months of group-based ST with TAU. At the end of treatment, 94 percent of the women in the ST group no longer met diagnostic criteria for BPD, a significantly greater reduction than in the 16 percent who no longer met criteria in the TAU group. Furthermore, ST led to significantly greater improvements on levels of general functioning and psychopathology in comparison to TAU. This study, therefore, provides further evidence for the efficacy of ST for BPD, although further research with larger samples and increased methodological rigor is needed to confirm this treatment's utility.

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Evidence for Good Psychiatric Management for Treatment of BPD

Empirical support for GPM comes primarily from the original RCT using GPM as a credible control condition against DBT. Despite initial study hypotheses, GPM was found to be as effective as DBT across all outcome measures, including self-harm, hospitalizations, BPD symptoms, a range of secondary clinical correlates such as depression, and functioning variables.[60] A two-year follow-up study[90] found that these improvements either continued or were sustained over follow-up. Once again, neither treatment was found to be superior to the other. These results suggest that GPM may be a viable alternative to specialized treatments for BPD, especially in contexts in which such treatments are not available. However, GPM has evolved since the original trial and has not been examined in its current iteration, that is, as a generalist approach without a once-weekly dynamically oriented psychotherapy component.

Meta-analyses for Treatment of BPD

Meta-analysis is a procedure for statistically combining the results of many different research studies by aggregating data though the conversion of divergent outcomes into a common metric, called an effect size. The effect sizes represent the strength of an effect (on the dependent variable) and standardizes findings across studies such that they can be directly compared. Meta-analyses focus on the *direction* and *magnitude* of the effects across studies; by combining results from multiple studies, meta-analysis allows for the statistical examination of potential moderators. Several stage- or level-based evidence rating systems place systematic reviews and meta-analytic studies at the top of the evidence hierarchy,[91–93] because they can protect against the biases or chance findings that may occur in any one study. Additionally, such studies can protect against allegiance effects,[94,95] which might persist across several studies carried out by one group of investigators, and allow for the exploration of moderators. Both systematic reviews and meta-analytic ones, like all research, can be subject to critique, but over the last decade there have been several guidelines developed to facilitate the conduct and reporting of such studies (A Measurement Tool to Assess Systematic Reviews, AMSTAR[96]; Meta-Analysis Reporting Standards, MARS[97]; and Preferred Reporting Items for Systematic Reviews and Meta-Analyses, PRISMA[98,99]).

To date there have been five published meta-analyses examining the treatment outcome for individual psychotherapies for BPD;[20,78,100–102] two published meta-analyses examining dropout;[103,116] one published meta-analysis examining outcome for group treatment of BPD;[104] several meta-analyses of medication use; as well as several other meta-analyses of DBT in various contexts (e.g., inpatient).[100,101,105–108,114–115,117–118]

The first meta-analysis[100] included seven studies of 262 patients. Six of the studies were of DBT and one was for MBT. The authors found that there were no differences between active treatments and TAU for many outcomes such as remission of diagnosis, anxiety, and depression; there was some evidence for reduction of suicidality and parasuicidality. The authors concluded that some problems experienced by BPD patients may be amendable to “talk” and behaviorally oriented therapies; however, they warned that the wide confidence intervals around the effect sizes render the findings unreliable. Hence, the authors suggested that all talk/behavioral treatments at that time should be considered experimental. These conclusions ran counter to the acceptance of DBT as a treatment of choice and its wide dissemination across the United States and Europe between 1991 and the early 2000s.

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The next published meta-analysis, by Kröger and colleagues,[78] reported findings examining 16 RCTs for DBT. They found an overall effect size of 0.39 for suicidal and parasuicidal behavior, which corresponds to a moderate effect.[109] However, their meta-regression model showed a negligible between-group effect size of 0.01 for trials in which DBT was compared with an active control or specific treatment for BPD.[60,76,79,110] This finding points to the presence of a possible moderator of effect size—the stringency of the control group against which the experimental treatment is measured—and suggests that clinicians may have options available to them in treating BPD besides DBT. Nevertheless, this meta-analysis focused only on DBT and included only RCTs, limiting the authors' conclusions and prohibiting them from examining treatment type and study design factors as moderators of effect size.

Stoffers and colleagues[101] for the Cochrane Collaboration published an updated quantitative review examining RCTs of psychotherapy for BPD. The authors noted that DBT was the most studied treatment, followed in no specific order by MBT, TFP, and ST. The authors conducted a number of subgroup analyses, separating effect size estimates by treatment and by outcome; however, this strategy resulted in only four treatment-outcome combinations that could be pooled across studies (DBT for anger, parasuicidality, mental health, and dropout). The rest of the treatment-outcome subgroups contained only single estimates. The authors concluded that DBT was helpful for these outcomes relative to TAU but, because of low power in these subgroup analyses (and thus low reliability of findings), could draw few other strong conclusions. Despite the conclusions, some people have interpreted the statement that DBT was the most studied treatment to mean that DBT had the most empirical support. However, that would be an erroneous conclusion. In fact, the opposite conclusion is perhaps more accurate. Given that there are more studies of DBT, we can feel more confident in its effect size and its equivalence to other active treatments, but there is no evidence for its superiority.

In a study of 20 RCTs with 1,375 participants, Oud et al.[102] found medium effects on overall BPD severity (ES = 0.59) and small-to-medium effects for DBT on self-injury (ES = 0.40). Other effects were inconclusive. The comprehensive published meta-analysis was conducted by Cristea et al.[20] It included 33 trials and over 2,000 patients. Similar to previous meta-analyses, the best-represented approach was DBT (12 trials). PDT had eight trials, and CBT had five trials. Effect sizes ranged from small to moderate = 0.32–0.44 across outcomes and across types of therapies. There were no differences between DBT and PDT treatments. In fact, the effect sizes were slightly (but non-significantly) higher for PDT ($g = 0.41$; 95 percent CI, 0.12 to0.69 [seven trials]) than for DBT ($g = 0.34$; 95 percent CI, 0.15 to 0.53 [nine trials]). Both DBT and PDT were more effective than control interventions, while CBT ($g = 0.24$; 95 percent CI, −0.01 to 0.49 [five trials]) and other interventions ($g = 0.38$; 95 percent CI, −0.15 to 0.92 [six trials]) were not. There were no differences in dropout between DBT and PDT. The authors conclude that psychotherapy, particularly DBT and PDT, are effective for BPD symptoms; nonetheless, effects are small, inflated by risk of bias and publication bias, and unstable at follow-up.

Barnicot et al.[103] used meta-analysis to examine dropout from treatments for BPD. The authors concluded that although there was substantial dropout, it was not much higher than what is typical for other disorders, and that BPD, when treated with specialized psychotherapies, should no longer be thought of as a high-dropout disorder. Despite this conclusion, the completion rates varied quite a bit, and this variation was unexplained. Additionally, the findings of Barnicot et al.[103] run counter to a recent meta-analysis examining premature discontinuation in adult psychotherapy by Swift and

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Greenberg.[111] They found that a personality disorder diagnosis was predictive of premature dropout. One way to understand this discrepancy between Baricot et al.[103] and Swift and Greenberg[111] is that specialized treatments for BPD may result in significantly less dropout than non-modified and specialized approaches, which was more common in Swift and Greenberg's[111] samples. This interpretation is consistent with the dropout rates in the RCTs for BPD, which tend to be about 20–25 percent as compared with early reports which were in the 50–65 percent range.[112]

More recently, McLaughlin et al.[104] examined group psychotherapy for BPD. The authors found 24 RCTs with 1,595 patients that compared group psychotherapy for BPD with TAU. The group treatment conditions included STEPPS, MBT, DBT, and ST. The authors concluded that group treatments were associated with greater symptom reduction when compared with TAU. However, there was a moderating effect for the context of the group. Two of the highest effect sizes were obtained from groups that were part of a comprehensive day program,[6,82] and thus groups used adjunctive to TAU, or as standalone, do not appear to have the same effect. See Chapter 14 on group therapy for patients with PDs

Regarding medications, the evidence for their efficacy from RCTs and meta-analyses suggests that the widespread use of medications in the treatment of BPD is not supported by the evidence.[101,105–108] Binks, et al.[100] examined ten studies of 554 patients, finding few and small differences between medications and placebo. They concluded that pharmacological treatment of people with BPD was not based on good evidence. Nosè et al.[106] reviewed 20 RCTs of 818 patients and found no differences between any medication examined and placebo for 22 drug–placebo comparisons. This included comparisons for instability and anger with antipsychotics and antidepressants, interpersonal relationship functioning treated with antidepressants, suicidality treated with antidepressants, mood stabilizers, or antipsychotics. A 2010 review of 21 pharmacological treatment studies of BPD and STPD suggested that antipsychotics were moderately effective for cognitive or perceptual symptoms, as well as for reducing anger.[105] Antidepressants had a small effect on anxiety symptoms, but were not effective for depression among these patients or for treating core PD symptomatology. In the most recent meta-analysis examining new studies since 2015, Storebø et al.[107] caution that antidepressants such as fluoxetine did not show efficacy for reducing suicidality and self-harm in BPD patients. This finding is consistent with Vita et al.,[108] who found no evidence that antidepressants reduce BPD dimensions. Thus, although some studies have found modest and small positive effects of medications, the findings are far from consistent and are associated with significant risks. As such, medications are often seen as adjunctive and to be used with caution. See Chapter 15 on Psychopharmacology of Personality Disorders for additional information.

Review Table 5.1 (see p. 124) for a summaries of meta-analyses and RCTs demonstrating effectiveness of various psychotherapies for BPD.

Crossing the Alphabet Divide: Deriving Evidence-based Principles

Given that there are several treatments available that have shown evidence of efficacy, often in multiple studies, what is a clinician to do? How is one to make sense of this alphabet soup of treatment and findings? There are several treatment implications of our review. First, there are multiple treatments available to patients with BPD and the

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Table 5.1 Levels of Evidence for the Effectiveness of Various Psychotherapies for Borderline Personality disorder

Treatment	Primary Citation	Overall Level of Evidence	Summary of Levels of Evidence
Dialectical behavior therapy (DBT)	Linehan (1993)[1]	Level A	• Level I: Seven meta-analyses[20,78,102,107,114–118] and two systematic reviews find support for DBT on diagnostic remission, BPD symptoms, behaviors such as self-harm and suicide, and secondary features such as depression and anxiety. • Level II: 14 RCTs[38,60,68,72,73,75–77,79,119–123] find support for DBT for a range of symptoms, including behavioral symptoms such as self-harm and suicide in particular.
Mentalization-based treatment (MBT)	Bateman & Fonagy (1999)[6]	Level A	• Level I: Three meta-analyses[20,102,107] and three systematic reviews[117,124,125] find support for MBT on improving clinical outcomes of BPD, including symptom severity, comorbid disorders, and quality of life. • Level II: Six RCTs[81,82,126–129] find support for MBT in improving suicidal and parasuicidal behaviors, medication use, social and interpersonal functioning.
Transference-focused psychotherapy (TFP)	Yeomans, Clarkin, & Kernberg (2006)[7]	Level A	• Level I: Three meta-analyses[20,102,107] find support for TFP to be effective in treating BPD symptoms including suicidality and parasuicidality. • Level II: Three RCTs[76,85,86] find support for TFP in a range of primary and secondary BPD features, particularly reflective functioning and attachment security.
Schema therapy (ST)	Young (1994)[8]	Level A	• Level I: Two systematic reviews [130,131]of ST find support for improvement in BPD symptoms, including reduction of early maladaptive schema. • Level II: Three RCTs[86,89,132] find support for ST in diagnostic criteria for BPD and quality of life.
Good psychiatric management (GPM)	Gunderson & Links (2008)[9]	Level B	• Level II: One RCT[60] for a version of GPM finds improvement in self-harm, hospitalizations, BPD symptoms, and secondary features.

Note:
Criteria Levels of Evidence:
Level of Evidence A: Good quality patient-oriented evidence.
Level of Evidence B: Limited quality patient-oriented evidence
Level of Evidence C: Based on consensus, usual practice, opinion, disease-oriented evidence, or Case series for studies of diagnosis treatment prevention or screening
Level I: Systematic review or meta-analysis of randomized controlled trials
Level II: Randomized controlled trial
Level III: Controlled trial without randomization
Level IV: Case controlled or cohort studies

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clinicians who treatment them. Although these treatments derive out of different theoretical orientations and do have some historical and conceptual 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 because they are derived from similar clinical experiences in adapting to the challenge of treating clients with BPD, as treatments have been developed and refined in the context of knowledge derived from the broader literature on psychotherapy for BPD.

We will distill principles that clinicians can use to guide their work with individuals with BPD. First with regard to the research literature:

1) There are five empirically supported treatments available to the practicing clinician for treating borderline personality disorder. The Big Five are DBT, MBT,TFP, ST, and GPM.
2) 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.*
3) In addition, there are several adjunctive treatments (DBT skills group, STEPPS, MOTR) that may be useful when combined with specialized treatments.
4) Despite this evidence, at this point there are few prescriptive indicators suggested in literature.

There are several similarities between treatments that are useful for therapists to reflect upon. These include:

1) Treatment is not expected to be brief, casual, or designed to be intermittent. All of these treatments are designed and conceptualized to be long-term, with clinical trials lasting one to three years and naturalistic treatment often lasting longer. Each of these treatments is designed to be weekly and for multiple hours per week. For example, TFP is twice weekly; DBT includes one hour of therapy per week plus a 3-hour group and available phone consultation.
2) These treatments include the provision of supervision and consultation for therapists (or intervision—that is, supervision by peers—for more experienced therapists), with the explicit goal of providing the therapist with support and protecting against therapist burnout, enactments in the treatment, passivity, iatrogenic behaviors, and colluding with clients' pathology.
3) Therapists treating patients with BPD should strongly consider training in one or more of the evidence-based treatments: DBT, MBT, TFP, ST, and GPM. All have books and training material available and have organized workshops, trainings, supervisions, and even online training modules available.
4) Given that BPD is heterogeneous, that only 50–60 percent of patients improve within one year, and that even those patients who do improve only do so partially, it is useful for a therapist to know more than one treatment approach, especially approaches that may cut across theoretical orientations.
5) Many of the evidence-based treatments for BPD utilize concomitant treatments (e.g., 12-step programs, skills groups) and group therapy in addition to individual therapy: DBT includes skills groups; MBT has traditionally included

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group therapy. Although TFP does not have a formal group component yet, adjunctive group treatments, including skills-based ones, are considered useful as long as there is communication between treaters and shared understanding of treatment goals. In fact, depending on the patient's issue, a TFP therapist may not only encourage but require involvement in group psychotherapy.

6) To avoid splitting across providers, each treatment emphasizes integration of different services received by clients and communication among providers. Related to this, there is some evidence that different treatment services provided within institutions are more effective than treatments across institutions.[113]
7) In these treatments, therapists tend to take an active role in treatment and are not passive listeners.
8) The therapist takes a thorough history from the patient, including past treatments. It is important to speak with informants, including referral sources, significant others, past treaters, and possibly others. Patients should provide permission to speak with such individuals. This may take some time to work through patients' ambivalence to involve others.
9) Once all information is obtained, and the therapist feels confident about their understanding of the patient's difficulties, this understanding should be explicitly shared with the patient. This typically includes the diagnosis, which of course needs to be done sensitively and without unnecessary stigmatizing of the patient. The patient's feedback should be considered, and a shared understanding of the difficulties should be sought and established. It is important to share the diagnosis with the patient for ethical reasons, but also because the patient may inadvertently find out or suspect the diagnosis. The therapist's withholding of the diagnosis can be interpreted as the diagnosis being dangerous and stigmatizing.
10) There is significant value in establishing a strong and explicit structure and frame for the treatment and clear roles and responsibilities of patient and therapist. Patient and therapist should strive to mutually agree on a hierarchy of priorities in treatment. The frame is set collaboratively. The therapist should try not to impose rules on the patient and should be vigilant to prevent patient acquiescence. Likewise, the therapist should not acquiesce to the patient if doing so feels uncomfortable or runs counter to the therapist's professional opinion.
11) The therapist adopts a nonjudgmental and flexible stance and empathizes with the client without reinforcing distortions in their perception of self or others.
12) Additionally, there is a common focus on emotion regulation, on views of self and others, 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 observing extreme vacillations in object-relations dyads (affectively charged mental representations of self and others in a relationship) and in integrating these extremes into a coherent whole, while ST 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 awareness of shifts in mentalizing from effective mentalizing processes to non-mentalizing modes.
13) There is a common focus on helping clients to link and integrate their emotions, thoughts, and behaviors, generally including a focus on self-observation as well as considering alternative perspectives.

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Conclusion

A number of psychotherapeutic treatments exist for BPD. These treatments hail from disparate theoretical foundations and come in a variety of formats, including individual and group therapies and as augmentation to other treatments. The evidence base for psychotherapy for BPD is strong, yet growing, showing moderate efficacy but with no one treatment consistently surpassing others. Consequently, clinicians and researchers should understand the similarities and differences among these approaches and begin to more effectively and coherently integrate across them. More work is needed to empirically evaluate the effectiveness of integrative approaches to treating BPD and how best to sequence or combine treatments and their elements. See Box 5.1 for relevant information for patients, families, and clinicians.

Conflict of Interest/Disclosure: The authors of this chapter have no financial conflicts and nothing to disclose.

Box 5.1. Resources for Patient Families and Clinicians

National Organizations for BPD

- BPD Resource Center. www.bpdresourcecenter.org.
- Treatment and Research Advancements for Borderline Personality Disorder (TARA4BPD). www.tara4bpd.org
- National Education Alliance for BPD (NEA-BPD). www.borderlinepersonalitydisorder.org

Self-Help Books for BPD

- Chapman AL, Gratz KL. *The Borderline Personality Disorder Survival Guide.* Oakland, CA: New Harbinger Publications; 2007.
- Friedel RO. *Borderline Personality Disorder Demystified: An Essential Guide for Understanding and Living with BPD.* rev. ed. New York: Da Capo Lifelong Books; 2018.
- Green T. *Self-Help for Managing the Symptoms of Borderline Personality Disorder.* Self-published; 2008.
- Kreisman JJ, Straus H. *I Hate You, Don't Leave Me: Understanding Borderline Personality Disorder.* Updated, rev. ed. New York: TarcherPerigree; 2014.
- Lee, T. (2016). Stormy Lives: A Journey Through Personality Disorder (Muswell Hill Press).
- Mason PTT, Kreger R. *Stop Walking on Eggshells: Taking Your Life Back When Someone You Care About Has Borderline Personality Disorder.* 3rd ed. Oakland, CA: New Harbinger Publications; 2020.
- Reiland R. *Get Me Out of Here: My Recovery from Borderline Personality Disorder.* Center City, MN: Hazelden Publishing; 2004.

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Books for Families of Individuals with BPD

- Gunderson JG, Hoffman PD. *Understanding and Treating Borderline Personality Disorder: A Guide for Professionals and Families.* Washington, DC: American Psychiatric Association Publishing; 2006.
- Kreger R. *The Essential Family Guide to Borderline Personality Disorder.* Center City, MN: Hazelden Publishing; 2008.
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- Porr V. *Overcoming Borderline Personality Disorder: A Family Guide for Healing and Change.* New York: Oxford University Press; 2010.
- Tusiani P, Tusiani V, Tusiani-Eng P. *Remnants of a Life on Paper: A Mother and Daughter's Struggle with Borderline Personality Disorder.* Baroque Press, 2014.

Other Online Resources

- BDP Central. Accessed Feb. 10, 2021. www.bpdcentral.com
- BPDWORLD. Providing information advice and support to those affected by personality disorders. Accessed Feb. 10, 2021. www.bpdworld.org
- National Institute of mental health. Borderline personality disorder. Accessed Feb. 10, 2021. www.nimh.nih.gov/health/topics/borderline-personality-disorder/index.shtml
- BPD Family. Facing emotionally intense relationships. Accessed Feb. 10, 2021. www.bpdfamily.com

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