Borderline personality disorder: Psychotherapy

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INTRODUCTION

Borderline personality disorder (BPD) is characterized by instability of interpersonal relationships, self-image, and emotions, and by impulsivity. Patients with BPD often receive mental health treatment [1,2]. The disorder is more widely studied than any other personality disorder [3]. Despite these efforts, patients with BPD continue to suffer considerable morbidity and mortality [4].

First-line treatment for BPD is psychotherapy [5-7]. Psychotropic medications are used as adjuncts to psychotherapy, targeting specific BPD symptom clusters. Adjunctive use of symptom targeted medications has been found to be useful [8].

Psychotherapy for BPD is reviewed here. The epidemiology, clinical features, course, assessment, and diagnoses of BPD and other personality disorders are reviewed separately. Pharmacotherapy for personality disorders is also reviewed separately.

- (See "Overview of personality disorders".)
- (See "Borderline personality disorder: Epidemiology, pathogenesis, clinical features, course, assessment, and diagnosis".)
- (See "Antisocial personality disorder: Epidemiology, clinical manifestations, course, and diagnosis".)
- (See "Narcissistic personality disorder: Epidemiology, pathogenesis, clinical manifestations, course, assessment, and diagnosis".)

- (See "Schizotypal personality disorder: Epidemiology, pathogenesis, clinical manifestations, course, and diagnosis".)
- (See "Personality disorders: Overview of pharmacotherapy".)
- (See "Narcissistic personality disorder: Treatment overview".)
- (See "Schizotypal personality disorder: Treatment overview".)
- (See "Borderline personality disorder: Treatment overview".)

- (See "Antisocial personality disorder: Treatment overview".)
- (See "Schizotypal personality disorder: Psychotherapy".)
- (See "Dissociative identity disorder: Epidemiology, pathogenesis, clinical manifestations, course, assessment, and diagnosis".)

APPROACH TO TREATMENT

This topic reviews psychotherapies for borderline personality disorder (BPD), their components, efficacy, and administration. Our approach to selecting among treatment options for BPD is described separately. (See "Borderline personality disorder: Treatment overview".)

PSYCHOTHERAPIES

Several psychotherapies have been developed or adapted to treat patients with borderline personality disorder (BPD), including [9]:

- Dialectical behavior therapy (DBT)
- Mentalization-based therapy
- Transference-focused therapy
- Good psychiatric management
- Cognitive-behavioral therapy (CBT)
- Systems Training for Emotional Predictability and Problem Solving (STEPPS)
- Schema-focused therapy

These psychotherapies share common elements, but they have different emphases in their overarching approaches. Some emphasize behavioral skills training (eg, DBT) [10-12] while others focus more on relationships and understanding the meaning of interactions with others (eg, transference-focused or mentalization-based therapy) [13-16].

Common factors — Factors common to these psychotherapies include [6]:

- Providing an active and focused intervention.
- Emphasizing **current** functioning and relationships.
- Targeting affective instability by teaching or helping with emotion regulation. (See "Borderline personality disorder: Epidemiology, pathogenesis, clinical features, course, assessment, and diagnosis", section on 'Affective instability'.)
- Targeting impulsivity by helping patients to observe feelings rather than acting on them. (See "Borderline personality disorder: Epidemiology, pathogenesis, clinical features, course, assessment, and diagnosis", section on 'Impulsivity'.)
- Targeting relationship difficulties by teaching or helping patients to be cognizant of their own feelings and those of other people that is often described as mentalizing or mindfulness. (See "Borderline personality disorder: Epidemiology, pathogenesis, clinical features, course, assessment, and diagnosis", section on 'Interpersonal difficulties'.)
- Improving social cognition dysfunctions by fostering a more coherent identity and enhancing a sense of self-agency and social competence.
- Psychoeducation is an essential part of BPD treatment [17] and a specified component of the psychotherapies below. Patients and families need to be informed about the disorder, its signs and symptoms, possible causes, its course over time, and treatment options. (See "Borderline personality disorder: Epidemiology, pathogenesis, clinical features, course, assessment, and diagnosis", section on 'Discussing the diagnosis'.)

  Educational materials for patients include a publication from the National Institute of Mental Health explaining the symptoms, course of illness, and treatment for BPD. The publication is available in a pdf format at this link. More comprehensive information about the illness is provided in books written for patients [18,19] and for families [20].

Each of the psychotherapies that follow is based on a manual that provides structure to the therapy and standardizes the techniques that are used. A manual enables clinicians to implement the treatment as intended and maintain consistency in its application over time.

Efficacy of psychotherapy — The effect of psychotherapy as a treatment has been examined in meta-analyses and clinical trials:

- A systematic review and meta-analysis of 33 clinical trials with 2256 participants examined the efficacy of a variety of psychotherapies for BPD [21]. Overall, the psychotherapies compared with a control intervention were effective for BPD-relevant outcomes (eg, a

combination of BPD symptom change, self-harm, and suicide combined) at post-test (g = 0.35, 95% CI 0.2-0.5) and at follow-up (g = 0.45, 95% CI 0.15-0.75). DBT (g = 0.34, 95% CI 0.15-0.53) and psychodynamic approaches (g = 0.41, 95% CI 0.12-0.69) were the specific types of psychotherapy that were found to be more effective than control interventions for BPD-relevant outcomes at post-test, but not at follow-up.

- In another meta-analysis of 14 trials with 1370 participants, the effects of psychotherapy (eg, CBT, interpersonal therapy, or psychodynamic therapy) versus control on quality of life (QoL) and level of BPD pathology in patients with BPD was examined [22]. Psychotherapies for BPD showed improvements in QoL (effect size d = 0.31, 95% CI 0.18-0.44) and BPD pathology (effect size d = 0.43, 95% CI 0.23-0.64). While positive effects were noted, effect sizes were small to moderate and more studies are needed to examine the impact of psychotherapy on QoL and long-term outcome.

Specific psychotherapies

Dialectical behavior therapy — DBT is a well-studied, evidence-based variation of CBT that includes an emphasis on behaviorally analyzing and managing a hierarchy of treatment targets, including suicidal/dangerous behavior, treatment-interfering behavior, and QoL interfering behavior. It consists of weekly individual psychotherapy with a DBT-trained therapist and group skills training utilizing evidence-based skills and interventions as delineated in the DBT skills manual for approximately one year [23].

The therapists treating these patients are expected to attend a regular consultation group to discuss issues and problems inherent in the treatment as well as to ensure that the therapy remains adherent to treatment principles. Another core feature of DBT is the availability of the therapist by phone or other means between sessions to provide coaching in the context of target behavior management and to facilitate the generalization of skills from therapy sessions to the natural environment.

As an example, a clinical trial randomly assigned 101 women with BPD and self-injurious behavior to receive DBT or community treatment over a two-year period of treatment and follow-up. Over the two-year period, fewer patients treated with DBT attempted suicide (23 versus 46 percent), used hospital emergency department services (43 versus 58 percent), or required psychiatric hospitalization (20 versus 49 percent) compared with patients receiving community treatment [10]. Fewer patients assigned to DBT dropped out of treatment.

Mentalization-based therapy — Mentalization-based therapy is primarily a psychodynamic therapy that also incorporates cognitive techniques. Patients are taught to observe their state

of mind at each moment, and to generate alternative perspectives of subjective experiences of themselves and others.

Randomized trials have found that BPD patients treated with mentalization-based therapy improved on multiple BPD outcomes compared with control conditions [13,15]. As an example, a trial randomly assigned 41 BPD patients to receive mentalization-based treatment or general outpatient psychiatric care. Patients in the experimental group received individual and group therapy in a partial hospital setting for 18 months, followed by an additional 18 months of outpatient treatment twice a week [13]. Eight years after intake for the trial, significantly fewer patients in the experimental group attempted suicide (23 versus 74 percent) or met criteria for BPD (14 versus 87 percent) compared with patients in the control group.

Transference-focused therapy — Transference-focused therapy is a psychodynamic psychotherapy that involves exploration, confrontation, and transference interpretations of emotionally charged issues that arise in the relationship between the patient and therapist. The aim is to correct the patient's tendency to perceive significant others in a distorted manner.

Randomized trials of transference-focused therapy for BPD have found the therapy to be efficacious compared with a control condition but less effective than another psychotherapy developed for BPD:

- A clinical trial of 104 women with BPD found that transference-focused therapy over one year reduced BPD symptoms, improved psychosocial functioning, and reduced suicide attempts and psychiatric hospitalizations compared with treatment by an experienced community psychotherapist [24].

- Schema-focused versus transference-focused therapy – A three-year randomized trial found that schema-focused therapy resulted in a greater proportion of BPD patients achieving remission of BPD symptoms compared with transference-focused therapy [11]. (See 'Schema-focused therapy' below.)

In our clinical experience, transference-focused therapy can be helpful to patients with BPD particularly among those patients who are functioning fairly well in their lives. Further trials are needed to determine its efficacy.

"Good psychiatric management" — “Good psychiatric management” is a manualized treatment developed to address shortages of mental health professionals, particularly those with training and experience in treating severe personality disorders [25,26]. It is intended for use by “generalist” clinicians, without expertise, including non-mental health practitioners. Compared with the other therapies listed here, this approach involves less of a distinct

conceptual model and less specified psychotherapeutic techniques. Instead, it provides a set of principles and practices to meet the patient's clinical needs and assist the general psychiatrist in avoiding many of the pitfalls that can occur in the treatment of BPD. Examples include:

- Diagnostic disclosure and psychoeducation about the disorder.
- Active case management with focus upon the patient's life outside of therapy.
- Goal setting and focusing on best ways to achieve them in order to convey that change is expected.
- Focusing on the individual's interpersonal hypersensitivity (eg, tendency to attach more meaning to trivial interpersonal interactions than warranted) in order to better understand their behavior; teaching how the disorder impacts relationships and how to acquire skills to better manage emotions within those relationships.
- Use of multiple treatment modalities (eg, Alcoholics Anonymous, Narcotics Anonymous) if indicated.
- Flexibility with regard to treatment duration and intensity.

A randomized trial compared "good psychiatric management" with DBT, a well-regarded, widely-studied intervention, in 180 outpatients with BPD [27] and found that outcomes did not differ significantly between good psychiatric management and DBT. Patients received weekly treatment for one year. Therapists for both groups received weekly supervision. Both therapies, as delivered in the study, were assessed by patients and audiotape reviewers, and found to be adherent to their respective treatment models. Sixty-two percent of patients completed the year of treatment, with no difference in retention between groups. At the end of one year, both groups experienced reductions in suicidal and self-injurious episodes, BPD symptoms, and improved functioning; no difference was seen between groups. Treatment gains were found to be sustained in both groups at two-year follow-up [28]. These results would benefit from further study in a well-powered, "noninferiority" trial. In our clinical experience, good psychiatric management is an effective approach to treatment of BPD. (See 'Dialectical behavior therapy' above.)

Cognitive-behavioral therapy — CBT employs cognitive therapies to address the patient's distorted cognitions about themselves and others, and uses behavioral strategies improve social and emotional functioning.

Several randomized trials comparing CBT (or cognitive therapies) with a control condition in patients with BPD have found mixed results for primary outcomes, including self-injurious

behavior [12,29-32]:

- A trial randomly assigned 30 BPD patients, who were engaged in self-harm activities and receiving treatment as usual, to receive manual-assisted cognitive treatment (MACT) or to a control condition [30]. Patients receiving MACT experienced less frequent self-harm at the intervention's completion compared with the control group; self-harm was less frequent and severe in the MACT group at six-month posttreatment follow-up. No difference was seen between groups in suicidal ideation and time to self-harm.

- The largest of the trials randomly assigned 106 patients with BPD to either CBT (a median of 31 sessions) plus treatment as usual or treatment as usual alone for 12 months [12]. No difference was seen in the primary outcome – a composite measure comprised of suicidal acts, psychiatric hospital admissions, and emergency center visits. The mean number of suicidal acts, a secondary outcome, was lower in the CBT group compared with the control group (0.9 versus 1.7).

It is not clear whether the mixed results from the trials reflect the efficacy of CBT for BPD or other factors, such as heterogeneity among the CBT interventions and other cognitive interventions studied.

Systems Training for Emotional Predictability and Problem Solving — STEPPS is an effective, CBT-oriented group therapy that includes skills training and family education [29,33]. STEPPS is primarily used as an adjunct to non-CBT-oriented psychotherapies but has also been used adjunctive to DBT.

Schema-focused therapy — Schema-focused therapy combines CBT and psychodynamic techniques with the aim of modifying maladaptive schemas. Schemas are mental structures that represent some aspect of the world such as oneself or others that are rooted in childhood experiences, and that are used to organize knowledge of the surrounding world.

Clinical trials have found schema-focused therapy to be an effective treatment for BPD [11,34]. Furthermore, combined individual and group schema therapy (IGST) appears to be superior to predominantly group schema therapy (PGST) or treatment as usual. As examples:

- A clinical trial of 32 randomly assigned patients with BPD compared an eight-month, 30-session schema-focused group therapy with treatment as usual [34]. Schema-focused therapy led to reduced BPD symptoms and improved global functioning, with a much larger proportion of patients no longer meeting BPD diagnostic criteria by the end of the trial compared with the control group (16 versus 94 percent).

- Schema-focused versus transference-focused therapy – A three-year randomized trial found that schema-focused therapy resulted in a greater proportion of BPD patients achieving remission of BPD symptoms compared with transference-focused therapy [11]. (See 'Transference-focused therapy' above.)

- In a multisite, international trial, 495 individuals with BPD were randomly assigned to treatment over a two-year period with PGST, combined IGST, or treatment as usual (eg, frequently DBT) [35]. At treatment end, individuals in the combined IGST group showed greater improvement on the Borderline Personality Disorder Severity Index-IV than those in the treatment as usual group or the PGST group (Cohen's d 1.14, 95% CI 0.57-1.71 and 0.84, 95% CI 0.09-1.59, respectively). Treatment retention was greater in the IGST arm than the PGST arm or the treatment as usual arm at both one and two years. Group and individual sessions appear to ameliorate different patient problems, with group therapy addressing social and work functioning, and individual therapy reducing suicide attempts.

Duration and intensity — The psychotherapies used in the clinical trials above were mostly designed to be delivered one or two times weekly for 6 to 12 months; some included additional group sessions. (See 'Efficacy of psychotherapy' above.)

Our clinical experience is that many, if not most, BPD patients require many months to years of treatment, which is consistent with the course of the disorder, severity of associated mood and behavioral problems, and the long-term process of achieving sustained insight, self-control, and improved occupational and social functioning. While some suggest a minimum of 20 sessions [36,37], we believe that the ability to maintain a consistent relationship with a therapist over many months and, in many cases, years helps the patient appreciate and work through the problems and interpersonal difficulties that are inherent in maintaining any long-term relationship. Patients (especially younger patients) with fewer and less severe symptoms, fewer comorbid conditions, less psychosocial impairment, and better interpersonal relatedness are likely to have better outcomes even with more limited treatment interventions.

The intensity of treatment varies with fluctuations in the severity of symptoms and associated risks. During acute periods of severe illness, the patient may require a brief inpatient stay (eg, to prevent suicidal behavior), participation in a partial hospitalization or intensive outpatient program, or multiple outpatient sessions weekly. Less frequent outpatient treatment may be needed during periods of mild symptoms and greater stability.

The decision to stop treatment optimally is made jointly by the patient and clinician. It is typically advisable to continue therapy until safety has been maintained for an extended period

and sufficient progress has been achieved in reducing the patient's symptoms and functional impairment.

SOCIETY GUIDELINE LINKS

Links to society and government-sponsored guidelines from selected countries and regions around the world are provided separately. (See "Society guideline links: Personality disorders".)

INFORMATION FOR PATIENTS

UpToDate offers two types of patient education materials, "The Basics" and "Beyond the Basics." The Basics patient education pieces are written in plain language, at the 5th to 6th grade reading level, and they answer the four or five key questions a patient might have about a given condition. These articles are best for patients who want a general overview and who prefer short, easy-to-read materials. Beyond the Basics patient education pieces are longer, more sophisticated, and more detailed. These articles are written at the 10th to 12th grade reading level and are best for patients who want in-depth information and are comfortable with some medical jargon.

Here are the patient education articles that are relevant to this topic. We encourage you to print or e-mail these topics to your patients. (You can also locate patient education articles on a variety of subjects by searching on "patient info" and the keyword(s) of interest.)

- Basics topic (see "Patient education: Borderline personality disorder (The Basics)")

SUMMARY

- Psychotherapy is first-line treatment for borderline personality disorder (BPD). Symptom targeted medication treatment is a useful adjunct to psychotherapy. (See 'Introduction' above and "Borderline personality disorder: Treatment overview".)

- Psychotherapies for BPD are generally active, focused on current functioning and relationships, as well as on managing the affective dysregulation, impulsivity, and social cognition dysfunctions characteristic of the disorder. (See 'Common factors' above.)

- Psychoeducation is an important component of psychotherapy for BPD. Patients and families need information about the disorder, its signs and symptoms, possible causes,

course over time, and treatment options. Pamphlets and books are available for patients and family members from numerous sources. (See 'Common factors' above.)

- Based on limited clinical trial results and our clinical experience, we consider the psychotherapies for BPD below to be comparably effective. Their availability varies geographically. Selection among them can be based on their availability locally and patient preference. (See 'Efficacy of psychotherapy' above.)

  - Dialectical behavior therapy
  - Mentalization-based therapy
  - Transference-focused therapy
  - “Good psychiatric management”
  - Cognitive and behavioral therapies
  - Systems Training for Emotional Predictability and Problem Solving (STEPPS)
  - Schema-focused therapy

- Dialectical behavioral therapy is a well-studied form and variation of cognitive-behavioral therapy (CBT) that includes an emphasis on managing suicidal and other dangerous behavior, treatment interfering behavior, and quality of life interfering behavior. (See 'Dialectical behavior therapy' above.)

- Mentalization-based and transference-focused therapies are primarily psychodynamic. Mentalization also incorporates cognitive techniques, in which patients are taught to observe their state of mind at each moment, and to generate alternative perspectives of their subjective experience of themselves and others. Transference-focused therapy involves exploration, confrontation, and transference interpretations of emotionally charged issues that arise in the relationship between the patient and therapist. (See 'Mentalization-based therapy' above and 'Transference-focused therapy' above.)

- “Good psychiatric management” is a manualized treatment providing a set of principles and practices drawn from clinical trials and experience to meet the patient’s clinical needs. (See '"Good psychiatric management"' above.)

- Multiple forms of CBT have been developed for patients with BPD, including schema-focused therapy. Combined individual and group schema-focused psychotherapy may be more efficacious than group schema-focused therapy alone. STEPPS, which includes skills training and family education, is primarily used as an adjunct to other, non-CBT-focused therapies. (See 'Schema-focused therapy' above and 'Systems Training for Emotional Predictability and Problem Solving' above.)

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