Psychotherapy and Psychosomatics

Received: February 9, 2011
Accepted after revision: May 22, 2011
Published online: November 25, 2011

Psychother Psychosom 2012;81:61–63
DOI: 10.1159/000329548

Treatment of Patients with Borderline Personality Disorder and Comorbid Posttraumatic Stress Disorder Using Narrative Exposure Therapy: A Feasibility Study

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An increasing number of women (0.8–2% of the general public) seem to be affected by borderline personality disorder (BPD) [1]. Whereas BPD is already characterized by a high rate of psychiatric problems, current evaluations indicate that the frequency of comorbid posttraumatic stress disorder (PTSD) ranges between 33 and 61% among patients with BPD [2–4]. Clinicians have frequently noted that a combination of BPD and PTSD leads to mutual amplification of symptoms and thus to most severe impairment of functioning on all levels. A main symptom of BPD concerns sudden, intensive and aversive tension that is difficult for these patients to endure and to regulate [5, 6]. When there is comorbid PTSD, BPD symptoms are potentially intensified by the related anxiety, hyperarousal and intrusions, triggering sudden, uncontrollable and incomprehensible attacks of tension and fear. This prompts a vicious circle of uncontrollable swings in tension and dysfunctional behavioral patterns (e.g. self-inflicted pain and injuries), which in turn makes it impossible to modify maladaptive core beliefs.

It has frequently been assumed that patients being treated for BPD can only start to confront traumatic experiences once they have been sufficiently stabilized [3]. Neuner [7] carried out a critical examination of the processes involved in stabilization and confrontation and concluded that little evidence suggests that a stabilization phase prior to trauma exposure would be useful. A suitable trauma-focused therapy for patients with BPD and comorbid PTSD seems essential in order to reduce the burden of symptoms and to help patients understand and integrate the traumatic experiences into their lives. So far, there have been few attempts to treat both BPD and PTSD simultaneously [8].

The present approach sought to test the feasibility of narrative exposure therapy (NET), a trauma-focused therapy suitable for both in- and outpatient settings which can be taught to clinically experienced therapists in a short-term training program and implemented in a comprehensive treatment for BPD patients with comorbid PTSD. Within an open trial, 10 women with BPD and comorbid PTSD were treated at the Center of Integrative Psychiatry in Kiel using NET.

NET is a standardized, controlled short-term intervention which is based on the core assumption that a maladaptive trauma-related network of memory representations has resulted from multiple adverse and fearful experiences [9]. NET is now considered to be a comparatively well-tested therapy approach for patients who have survived different types of trauma, ranging from domestic violence and emotional neglect to organized violence [10, 11]. It aims primarily at reducing PTSD symptoms by changing associative memory related to the traumatic experiences through recall of the event and exposure, assigning each event the respective time and place at which it had been experienced. This promotes a coherent autobiographical memory associated with the sensory, affective and cognitive cues of the event [12], and in addition has nondissociative effects [6].

After detailed psychoeducation, the patient is encouraged to narrate the events of his/her life in a chronological order, from birth to the present day, by using a 'lifeline' (symbolized by a line or rope and flowers representing well-remembered positive, and stones representing the traumatic events). In a client-friendly therapeutic environment, it is possible to link the various components (thoughts, emotions, body reactions, contextual information) and integrate them into the patient's biography. For a more detailed explanation of the basic theoretical assumptions and the method, we refer to Neuner et al. [12] and Schauer et al. [13].

During the period between January 2009 and May 2010, 12 women presenting with BPD and comorbid PTSD were recruited from our clinic. After psychological diagnoses considering the in- and exclusion criteria, of those informed about the study, no one refused; 2 women dropped out for practical reasons. Six women underwent therapy in a hospital, 3 on an outpatient basis, and 1 patient started treatment in hospital but then continued her therapy as an outpatient. Whenever possible, the medication administered to the patients during treatment was kept stabile. On average, the women were 33 years old (range: 19–45 years), and all had already received some form of psycho- and pharmacotherapy, although none had received trauma-focused treatment before.

Prior to treatment, a diagnosis was reached by conducting a standardized and structured clinical interview based on the Mini-International Neuropsychiatric Interview [14] and the Structured Clinical Interview for DSM-IV Axis II Personality Disorders [15]. After the initial diagnosis, the Posttraumatic Stress Diagnostic Scale (PDS) was applied as an interview [16, 17]. This instrument records PTSD symptoms in accordance with the DSM-IV. Depression symptoms were assessed by clinician ratings using the Hamilton Depression Rating Scale (HAM-D) [18, 19], as well as by means of the Hopkins Symptom Checklist 25 (HSCL-25) [20–22]. The severity of BPD symptoms was evaluated by self-

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Table 1. Changes in symptoms from before to 6 months after therapy

	Scores		Z	p (one-tailed)	Hedges' g (effect size)
	before therapy	6 months after therapy			
PTSD symptoms					
PDS	35.0 (8.0)	29.0 (19.0)	–1,887	0.03*	0.92
Depression					
HAM-D	29.5 (12.25)	25.0 (13.75)	–1,837	0.033*	0.89
HSCL-25	2.78 (0.53)	2.48 (0.92)	–1,599	0.055**	0.59
HSCL-25 – depression	3.1 (0.68)	2.8 (0.96)	–1,122	0.13	0.55
HSCL-25 – fear	2.73 (0.7)	2.3 (1.06)	–1,632	0.052**	0.74
BPD symptoms					
BSL-23	64.5 (18.0)	49.5 (19.75)	–1,428	0.077**	0.85
Dissociation					
FDS	22.5 (21.62)	8.6 (10.25)	–2,143	0.016*	0.87

Values denote medians with interquartile ranges in parentheses. * $p < 0.05$; ** $p < 0.1$.

assessment with the aid of a short version of the Borderline Symptom List 23 (BSL-23) [23], and dissociative symptoms were recorded by means of the Fragebogen zu dissoziativen Symptomen (FDS) [24]. Six months later, the same instruments were applied by an independent researcher who interviewed the patients using the HAM-D, while PDS, BSL-23, HSCL-25 and FDS data were gathered using a self-rating procedure. Furthermore, at the 6-month follow-up examinations, important events that had occurred since the end of therapy were discussed.

After receiving a detailed explanation of the study, comprehensive psychoeducation and signing an informed consent, NET was carried out in accordance with its manual [13]. Each session generally lasted for 90 min and took place once or twice a week, depending on prior agreement. Experienced clinicians who had received a 2-day training on NET by a multiprofessional team carried out all sessions. Weekly team meetings and biannual supervision assured adherence to the guidelines outlined in the manual. The study was approved by the local ethics committee and conforms to the ethical guidelines of the Helsinki Declaration.

Overall, it was possible to carry out NET for all patients. On average, 14 NET sessions (range: 11–19 sessions) were necessary, taking into account that the number of sessions depends on the amount and severity of traumatic events. Where required, upon completion of the NET, patients received a further 1–2 sessions with the aim of developing prospects for the future.

Based on Wilcoxon tests, there was a significant reduction in symptoms of PTSD ($p < 0.05$) as assessed by the PDS, depression ($p < 0.05$) as assessed using the HAM-D, and dissociation as assessed by the FDS ($p < 0.05$). With respect to BPD symptoms, recorded using the BSL-23, the noted drop would become significant if an α level of 0.10 were used (table 1).

As predicted by the theoretical assumptions supporting NET, it could be observed by the therapists that there was a temporary increase in recollecting, reflecting upon and classifying traumatic experiences together with the related negative emotional states. This behavior was expected, especially for dissociative patients after they had overcome their hyperinhibition, i.e. apparent amnesia for traumatic events, a condition that sometimes persists for several years [6, 25]. This is also reflected in the marked reduction in dissociative symptoms. By the same token, increased occasional suicidal thoughts and marked states of tension with a will to self-inflict harm were noted in some patients, although these feelings appeared *before* discussing the related events. After remission of the trauma-related symptoms had started, however, the patients reported that the urge to inflict pain or injury on themselves had faded. It seems that the parallels between the stages of the patients' lives and the events discussed had thereby become obvious. Consequently, these changes should not be regarded as a deterioration in a patient's condition – a false assumption frequently made –, but they should rather be interpreted as a first step forward from a therapeutic point of view. The increases in symptoms basically indicate that an adequate process of integration of traumatic experiences has been initiated.

It should be mentioned that various factors such as difficult personal and psychosocial circumstances might have impaired the achievement of even better results. At the 6-month follow-up, nearly all patients reported such problems (e.g. moving house, interpersonal/relationship problems, bereavement), which most likely had negatively affected their mood and symptoms.

The patient pool for our pilot study was drawn from a clinical setting with participants who exhibited very severe symptoms. Nevertheless, the results need to be interpreted with care as the number of cases was small and the trial was not controlled. To support and complement this initial, positive experience with NET as a trauma-focused procedure for the treatment of (female) patients with BPD and PTSD, further tests including randomly controlled studies are a next step.

So far, the present study has demonstrated the feasibility of NET, in that a team of clinicians (psychologists and psychiatrists) who has received a 2-day training in NET, as well as subsequent group supervision, can within weeks achieve a marked improvement in borderline patients with comorbid PTSD using NET as a

treatment module, even under the often less than ideal conditions in a psychiatric ward. Thus, our findings demonstrate that NET can be used with borderline patients in a standard clinical setting (out- and inpatient).

Disclosure Statement

The authors of this article hereby declare that no conflict of interest exists with regard to the study presented in this paper.

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