Psychoanalytic Treatment of Borderline Personality Disorder

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After the recent decade of the brain and in the present era of evidence-based practice, psychoanalytic treatment of personality disorder is being challenged. Not only are managed care companies questioning coverage for psychoanalytically oriented treatments, but other therapies are being promoted as having a better empirical foundation. Certainly, psychoanalytically oriented practitioners have been slow to research their treatment rigorously. This has begun to change, however, and a number of studies are underway or have been published (Kcshele et al., 2000). The results suggest that psychoanalytic treatment of personality disorder can be modified to treat successfully even some of the most difficult patients.

Borderline personality disorder (BPD) is associated with serious morbidity. Nearly 10% of patients eventually commit suicide, and between 60% and 80% engage in seriously damaging self-injury at some point. Furthermore, patients make widespread use of mental health services and are frequently hospitalized. In this brief review, I will summarize some of the evidence for the effectiveness of psychoanalytic treatment for BPD and discuss its implications for the development of psychiatric services.

Limitations and Challenges to Current Research

A major problem for psychoanalytic treatments of BPD has been a reliance on cohort studies in which groups of patients are treated with a non-specific psychoanalytically oriented program, usually as inpatients, and followed over time. Of course, this can mean that any improvement that occurs could be a result of the passage of time rather than the treatment itself. Although the reported dropout rate is high at around 45%, the results are encouraging, indicating that personality change itself may take place, in addition to improvement in psychiatric symptoms (Bateman and Fonagy, 2000).

This limited research approach to personality disorder was challenged by the publication of a randomized controlled trial of a new behavioral treatment for BPD. Linehan et al. (1991) demonstrated that dialectical behavioral therapy (DBT) was effective in helping female patients with BPD. Therapy was conducted weekly and was offered both individually and in groups for one year. Interventions for patients receiving treatment-as-usual were not controlled. Twenty-two female patients were assigned to DBT and 22 to the control condition. Assessment was carried out during and at the end of therapy and again after one year follow-up. The dropout rate was low at 16%. Control patients were significantly more likely to attempt suicide, spent a longer time as inpatients over the year of treatment and were more likely to drop out of those therapies to which they were assigned. However, there were no between-group differences on measures of depression, hopelessness or reasons for living. Follow-up at one year found no between-group differences (Linehan et al., 1993). Comparing control patients who were in stable therapy with those who received DBT led to the disappearance of some of the differences. For example, although the DBT subjects had fewer suicidal acts, there was no difference in the medical risk of the behaviors. Controlled studies of psychoanalytic therapy have only recently been instigated. Stevenson and Meares (1992) reported on 48 patients with BPD treated with twice-weekly psychoanalytic psychotherapy for one year. Patients acted as their own controls. Significant improvements in number of episodes of self-harm and violence, length of hospital admissions, and other measures were observed in the 30 patients who completed therapy. Of these patients, 30% no longer fulfilled criteria of BPD at the end of treatment. Improvement was maintained over one year. More recently, the same authors (Meares et al., 1999) compared the outcome of the same 30 patients with 30 further patients who were referred to the clinic but for whom no treatment was immediately available. Patients who received psychotherapy were significantly improved in personality disorder scores, while untreated patients were unchanged.
Despite the promising results from these studies, none of them matched the rigor of the study of DBT. An adequate design requires randomization of patients, is prospective, has a clearly described intervention, uses outcome measures specific to the condition being treated, and includes adequate follow-up since BPD is a chronic condition. In a perfect world, psychotherapeutic treatment would stimulate the development of the psychological capacities necessary to withstand the normal stresses and strains of everyday life. There is accumulating evidence that psychodynamic treatments are associated with gradual improvement after the cessation of treatment whereas behavioral treatments are not. This is important for costs of future health care. Cost-effective treatments are those that stimulate permanent and enduring change. Palliative treatment, which brings rapid but temporary relief, may have short-term gains but long-term costs. In the terminology of psychotherapy: remoralization or instillation of hope is quick but temporary, remediation of symptoms takes longer but may be enduring, but the rehabilitative or long-term effects of a treatment are devoutly wished for and yet elusive.

**RCT of Psychoanalytically Oriented Treatment**

With all this in mind, we set about developing a randomized controlled trial (RCT) of a psychoanalytically oriented treatment of BPD (Bateman and Fonagy, 1999). The severity of the patients' symptoms, many of whom had received compulsory treatment in secure settings and most of whom had made serious attempts on their life in the six months prior, meant that treatment in a partial-hospitalization program was necessary. Forty-four patients were randomized either to a psychoanalytically informed partial-hospitalization program or routine general psychiatric care. Treatment included individual and group psychoanalytic psychotherapy for a maximum of 18 months. Outcome measures included frequency of suicide attempts and acts of self-harm, number and duration of inpatient admissions, use of psychotropic medication, and self-report measures of depression, anxiety, general symptom distress, interpersonal function and social adjustment. Patients in the partial-hospitalization program showed a statistically significant decrease on all measures in contrast to the control group, which showed limited change or deterioration over the same period. Improvement in depressive symptoms, decrease in suicidal and self-mutilatory acts, reduced inpatient days, and better social and interpersonal function began after six months and continued to the end of treatment at 18 months. The dropout rate was low at 12%. Long-term follow-up was built into the study, and patients who participated in the original study were assessed every three months after completion of the treatment phase (Bateman and Fonagy, 2001). Patients who completed the partial-hospitalization program not only maintained their substantial gains but also showed a statistically significant continued improvement on most measures in contrast to patients treated with standard psychiatric care, who showed only limited change during the same period. Their continued improvement in social and interpersonal functioning suggests that longer-term changes were stimulated. The control group used more of all types of health and social care monitored in the study including attendance at emergency rooms, particularly following impulsive acts of self-harm. The maintenance of a reduction in episodes of self-harm and suicide attempts (Figures 1 and 2) and low rates of hospital admission in the patients with BPD who completed a psychoanalytically oriented partial-hospitalization program (compared with those patients who received standard psychiatric care) reduced to a minimal level the need for costly emergency treatment and expensive inpatient care. This suggests considerable cost savings following treatment.

**Effective Components of Psychoanalytic Treatment**

The program offered in this study was complex and no process measures were used, making it difficult to identify the effective components of the treatment. But similar criticisms apply to all other treatments of BPD, including DBT. The treatment was organized around BPD as a disorder of attachment and mentalizing capacity--a difficulty in thinking about others as having an inner world with feelings and conceptions different from one's own--and targeted four main areas: identification and appropriate expression of affect, development of stable internal representations, formation of a coherent sense of self, and capacity to form secure relationships. Interventions were structured according to a hierarchy. The first aim was to help the patient to improve affect control, followed by targeting internal representations through a focus on mentalizing capacity. Finally the sense of self and the detail of the dynamics of the relationship were investigated through transference exploration in the individual and group sessions.
This program and other treatments shown to be moderately effective, including DBT, have the following common features: 1) are well-structured; 2) devote considerable effort to enhancing compliance; 3) have a clear focus, whether that focus, is a problem behavior or an aspect of interpersonal relationship patterns; 4) are highly coherent to both therapist and patient, sometimes deliberately omitting information incompatible with the theory; 5) are relatively long term; 6) encourage a powerful attachment relationship between therapist and patient, enabling the therapist to adopt a relatively active rather than a passive stance; and 7) are well-integrated with other services available to the patient.

One way of interpreting these observations might be that part of the benefit that personality-disordered individuals derive from treatment comes through the experience of being involved in a carefully considered, well-structured and coherent interpersonal endeavor. What may be helpful is the internalization of a thoughtfully developed structure, the understanding of the interrelationship of different reliably identifiable components, the causal interdependence of specific ideas and actions, the constructive interactions of professionals, and, above all, the experience of being the subject of reliable, coherent and rational thinking. Social and personal experiences such as these are not specific to any treatment modality. Rather, they are correlates of the level of seriousness and the degree of commitment with which teams of professionals approach the problem of caring for this group who, it may be argued on empirical grounds, has been deprived of exactly such consideration and commitment during their early development and, quite frequently, throughout their later life (see review by Zanarini and Frankenburg, 1997). While this suggestion is speculative, it may also be helpful in distinguishing successful from unsuccessful interventions and pointing the way to more effective services.

Conclusions and Future Research Considerations

It is no longer tenable to suggest that personality disorder is untreatable. Patients deserve treatment. There is increasing evidence that psychoanalytic treatment is effective in treating borderline personality disorder. Our trial had a longer follow-up period than any other RCT of BPD and a low dropout rate. It has demonstrated long-lasting changes, with patients showing a marked reduction in service usage.

The questions now concern who should be treated, where and with what type of therapy. We neither know who should be treated as an inpatient, day patient, or outpatient nor who responds best to a psychoanalytically based program and who to a behavioral program, or if patients need both for different aspects of their problems.

What we do know is that both types of treatment are helpful in improving the lives of individuals with BPD, and managed care companies need to support services with appropriate conceptual models and an organized and thoughtful pattern of service.

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References:

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