Psychotherapy for borderline personality disorder: Where do we go from here?

Peter Fonagy, Patrick Luyten, Anthony Bateman

Submitted to: JAMA Psychiatry

Borderline personality disorder (BPD) is one of the most prevalent, and most disabling, personality disorders. There is increasing consensus that the disorder is characterized by three related core features: severe emotion dysregulation, strong impulsivity, and social-interpersonal dysfunction.[1] Individuals diagnosed with BPD were historically considered to be "hard to reach" and pessimism with regard to treatment prevailed. This view has changed over the past two decades, mainly as a result of emerging evidence for the efficacy and cost-effectiveness of specialized psychotherapies for individuals with BPD.[2,3]

The study by Cristea and colleagues[4] in this issue represents a new and major leap forward in this regard, as it heralds the coming of age of research on the effectiveness of psychotherapy for BPD. Cristea et al. report a meta-analysis including 33 studies of specialized psychotherapy either as a standalone treatment or as an add-on to non-specialized psychotherapies in adult patients diagnosed with BPD. Overall, specialized psychotherapy emerges as moderately more effective than non-specialized psychotherapy in reducing borderline-relevant and other outcomes, such as general psychopathology and service utilization, with no differences between specialized psychotherapy as a standalone or as an add-on to usual treatment. Importantly, these effects were typically maintained up to 2-year follow-up. Very few adverse events were reported, suggesting that psychotherapy for BPD is both effective and safe. With regard to the different treatment approaches, dialectical behavior therapy (DBT) and psychodynamic therapy emerged as more effective than non-specialized psychotherapy or treatment as usual (TAU); no such differences were found for cognitive therapy and other interventions. However, there was evidence of risk of bias in published studies and publication bias, particularly with regard to studies reporting follow-up data.

While these findings provide further support for the cautious optimism with regard to the role of specialized psychotherapy (and psychotherapy more generally) in treating BPD, Cristea et al.'s meta-analysis also highlights important limitations and concerns that the field needs to urgently address.

Cristea et al. found that differences between specialized and non-specialized therapies, although significant, were small to moderate, suggesting only a slight advantage of specialized psychotherapy. In fact, correcting for publication bias by adjusting effect sizes for missing studies led to even smaller differences, which disappeared on follow-up. Furthermore, studies that used strong control conditions (e.g., with *ad hoc* developed control treatments and/or manualized treatments such as structured clinical management (SCM)) showed no significant differences between specialized psychotherapy and control conditions. Do these findings mean that specialized psychotherapies are actually no more effective than non-specialized psychotherapy? Perhaps, particularly as Cristea et al. speculate that the superior outcomes of specialized treatments and strong control conditions could be explained by the "special attention" BPD patients received in such studies. Yet, the authors also raise the possibility that the superiority of these outcomes is rooted in their highly structured and often carefully manualized design. Consistent with this, we have argued that the coherence, consistency, and continuity of specialized treatments for BPD are crucial because they provide cognitive structure for a patient group that lacks metacognitive organization.[5] The importance of structuring of subjective experience as part of treatment has influenced how therapists—including the therapists in the TAU arm of trials—work with patients with BPD, so outcomes may have improved in TAU because iatrogenesis is likely to have decreased with the waning of unfocused exploratory and supportive interventions.[6] Control conditions,

particularly those in more recent trials, thus were not truly "non-specialized" treatments with smaller effects. If this is true, not only is it evidently good news for patients and clinicians; it would also point to how interventions could be made simpler without compromising their effectiveness. The finding that treatment intensity, in terms of duration and hours of therapy, was not related to outcomes also suggests further changes could be made to the current complex and long term specialist treatments without losing effectiveness.

Recommendations based on the Cristea et al. meta-analysis are to some measure determined by inclusion criteria, as direct comparisons of active treatments were excluded, based on the premise that few, if any, differences between specialized psychotherapies for BPD can be expected. Yet, this decision may have disadvantaged specific types of specialized psychotherapies, such as schema-focused therapy and general psychiatric management, which have been mostly investigated in studies comparing these versus other active treatments. Furthermore, while clustering of treatment types such as TFP and MBT under the heading of psychodynamic therapies, may be appropriate from some perspectives (the orientation of the developers), it makes less sense from others (e.g., the length of training required for each). Lumping treatments together may obscure potential differences in effectiveness (are all "cognitive-behavioral" therapies the same?). Modality labels may simplify—and suit payers—but are scientifically unsound if they are not directly linked to change mechanisms. Our focus on labels of convenience obscures understanding of mechanisms, which is the sole path to increase the effectiveness of BPD therapies.[7]

The validity of meta-analytic results is invariably threatened by unknown comorbidity and excessive within-diagnosis heterogeneity—and rarely more so than with BPD, where diagnosis is challenged by high temporal instability and poor convergent and discriminant

validity.[8] The various evidence-based treatments included in the present meta-analysis may have studied different populations and thus may be differentially effective in different subtypes of BPD. For example, MBT was superior over SCM only in BPD patients with multiple Axis II diagnoses.[9]

Yet, at the same time, the subtyping of BPD has been relatively unsuccessful. Multilevel factor analytic studies of personality disorder symptoms have suggested that BPD may be most parsimoniously seen as part of a "general personality disorder" factor rather than one of a number of personality disorder diagnoses.[10] If BPD is largely an indicator of vulnerability to personality disorder diagnoses, then perhaps we are wrong to think about BPD as a disorder; rather, we could conceive of its core symptoms as indications of a relative lack of capacity to withstand adversity. The "specialist" therapies found to be effective in BPD may have in common an unwavering and consistent focus on this core feature of BPD, which brings about improvements. More research is needed to substantiate these assumptions, however.

We were surprised that Cristea et al. found no evidence that the developers of specialized psychotherapies produced superior outcomes to replication studies—in contrast to a pattern that has been well demonstrated in other domains of psychotherapy.[11] Its absence may suggest a remarkable stability of findings or insufficient replications. The large differences in both treatment intensity and duration of psychotherapies for BPD, and the differences in training burden entailed for these various therapies, highlight the need for cost-effectiveness research. Furthermore, to decrease the risk of publication bias, Cristea et al. rightfully call for advanced registration of trials; this could be strengthened if study designs were reviewed by journals before results became available, and by triple-blind data analysis of data.[12]

In conclusion, while Cristea et al.'s study will undoubtedly provide a major impetus to future research on the effectiveness of psychotherapy for BPD, their findings make it clear that much remains to be done in terms of the development, evaluation, and implementation in routine clinical care of effective psychotherapy for this highly debilitating condition.

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