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How do art therapists structure their approach to borderline personality disorder?

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ABSTRACT

This paper outlines a study which sought to understand how art therapists structure their approach to treating people who experience borderline personality disorder features. It outlines the understanding of the condition, controversies around diagnosis and its use by evidence based psychological therapies as a guide for structuring therapy. The paper considers how art therapists might utilise research to improve art therapy for this distressing condition. The authors argue that before undertaking clinical trials, art therapists need to build theory inductively so that there is clarity about what is tested. They surveyed art therapists internationally to try to understand how whether there was consistency in how they structured their approach and received usable description of 226 interventions with over 140 names. The results indicate that most art therapists carefully prepare service users for treatment through sharing a clear understanding of the condition and treatment aims and pay particular attention to the attachment issues involved. The study concludes by suggesting any trial of art therapy with borderline personality disorder features should include these structures in the approach studied. The authors suggest that the existing taxonomy for art therapy does not describe the approach of practitioners take and recommend terminology should reflect structure and not therapist intentions.

Both authors work as art therapists within the UK National Health Service and specialise in the treatment of people diagnosed with borderline personality disorder (BPD). Current research evidence (reviewed below) suggested that this group require a specifically tailored approach in psychological therapy, whatever the theoretical model of the practitioner. Our clinical experience as art therapists convinced us that this is the case for art therapy too. Moreover, we suggest that the number of people on art therapists' caseloads needing a tailored approach is likely to be substantial because the diagnosis of BPD is often erratically applied and remains highly controversial as a clinical construct. Many adults who use art therapy service will have had the severe attachment traumas which result in problems regulating affect, sense of self and managing supportive interpersonal relationships that the BPD diagnosis attempts to describe. If this was the case then it was clearly under researched area for art therapy.

In this paper we discuss how art therapy research might develop in relation to the difficulties the BPD diagnosis seeks to describe. We argue that recent experience in art therapy research indicated that attempting to address the deficit in evidence by leaping to undertake clinical trials cannot be viewed as a useful strategy because it misses out a vital, preparatory, step. To support our argument we critique the difficulties in conducting previous clinical trials in art therapy. We suggest that careful inductive research is required to build theory before deductive approaches, such as trials, tests theory. The study described in the present paper seeks to make a contribution to that preparatory phase. This involved surveying art therapists in relation to their approach to treating the people who experience the difficulties involved in BPD.

We begin the paper by defining the terms used to define BPD difficulties. We then look at how those terms have been applied to art therapy in order to shape our research approach. Following this we discuss how the results of our research might contribute to an overarching research approach which might construct safe and effective art therapy for this important clinical population.

Borderline personality disorder as a construct for treatment

The International Classification of Mental and Behavioural Disorders (ICD-10, 2010) defined personality disorder as: "A severe

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disturbance in the characterological condition and behavioural tendencies of the individual, usually involving several areas of the personality, and nearly always associated with considerable personal and social disruption." (p. 252)

The original use of the term "borderline" was used to define the overlapping states of psychosis and neurosis. It was based on a crude observation that people who could not be classed as psychotic could experience transient psychotic like states. Even today the diagnostic classification of BPD remains controversial as a strategy for establishing a reliable or useful clinical diagnosis (Widger & Samuel, 2005). Criticisms of the concept were voiced by feminists who noted a male gender bias in their study of how clinicians formulate models of adult female maturity particularly in relation to BPD (Broverman, Broverman, Clarkson, Rosenkrantz, & Vogel, 1970; Burt, 1996). Eastwood (2012) noted that whilst 75% of those diagnosed with BPD were female, the DSM version III (1980) did not include any female authors in its formulation.

Sadly, the receipt of a diagnosis of BPD has tended to result in disrespectful and often unhelpful treatment by mental health services. Because of this, in 2003 the National Institute for Mental Health England issued policy implementation guidance entitled "Personality disorder: no longer a diagnosis of exclusion". The guidance was issued noting that whilst the condition is common (estimating, cautiously, that 10–13% of the UK adult population and between 36 and 67% of adult mental health population meet diagnostic criteria) those suffering the condition were often poorly served by the National Health Service. Many were left to the margins of care and relied on accident and emergency services or treatment via inappropriate acute psychiatric ward admissions. The authors of the guidance admitted the condition was poorly understood by clinicians and the behaviour of those with personality disorder evoked high levels of anxiety in professionals. A service user concurred, stating: "Personality disorder is the label given to the service users psychiatrists dislike" (National Institute for Mental Health England, 2003, p. 14).

The track record for psychological therapy treatment for BPD has been similarly problematic. A review of a long term study of BPD during treatment Stone (1990) suggested common forms of psychological therapy had resulted in harm:

> "It seems to us that there is no way to avoid the conclusion that some psychosocial treatments practiced currently, and perhaps even more commonly in the past, have impeded the borderline's capacity to recover following the natural course of the disorder and advantageous changes in social circumstances." (Bateman & Fonagy, 2006, p. 96)

A study by Hummelen, Wilberg, and Karterud (2007) noted the very high attrition rate in psychodynamic approaches. They interviewed 96 service users who had dropped out of group analytic treatment and reported that most found the interpersonal challenge and psychoanalytic basis of the therapist's comments were beyond their ability to understand. It is possible that those who experience BPD difficulties may be particularly at risk from the wrong form of psychological treatment because they experience interpersonal difficulties. Risk from art therapy had been identified as a neglected discourse and there is currently much that is not known about matching treatment to service user need in art therapy (Springham, 2012a).

Whilst noting the controversy around the BPD diagnosis, evidence exists that the problems it seeks to address have utility for research. Levy (2005) expert review of the attachment theory evidence indicated that while the relationship between BPD and a specific attachment category is not yet obvious, there is little doubt that BPD is strongly associated with early attachment insecurity. Levy suggested attachment insecurity was a relatively stable characteristic of the BPD individual, particularly in conjunction with subsequent negative life events. It has been estimated that 84% of BPD service users respectively reported experience of neglect and emotional abuse from both parents before the age of 18 years with emotional denial by the caretakers of their experience (Linehan, 1995; Zanarini, 2000). Neurobiological studies showed that those diagnosed with BPD appeared to have marked difficulties processing Oxytocin in trust games (Bartz et al., 2011), a lower threshold for the activation of the fight or flight system (Fonagy & Luyten, 2009), and high susceptibility to be destabilised once the amygdale had been stimulated (Arnsten, 1998). Studies such as these have the potential to legitimise the experience of those diagnosed with BPD. Because of this some have argued that that the term BPD offered a guide for structuring psychological therapy. For example, art therapy service users described how the term BPD carries great prejudice in mental health settings, but suggested the problems the diagnosis seeks to identify have utility for structuring the treatment approach attempted by art therapists (Morgan, Knight, Bagwash, & Thompson, 2012).

As a broader understanding of the phenomena that the term BPD attempts to represent has developed, condition specific psychological therapies have emerged based on those formulations. Whilst these have emerged within distinct therapy schools, they appear to have many common features in relation to managing the attachment processes and communication needs involved in therapy. In 2009 the UK National Institute of Clinical Excellence guidance summarised psychological therapy with BPD by stating that when providing any form of psychological treatment for people with BPD, especially those with multiple co-morbidities and/or severe impairment, care workers should share a clear understanding of the treatment approach with both the service users and other care working involved in treatment, avoiding as much ambiguity as possible. There should be a consistent approach with a particular emphasis on managing transitions and breaks in therapy. Lastly brief therapy should not be attempted with those with BPD symptoms.

It is unclear how many people who meet criteria for BPD enter art therapy treatment. Given the range of settings that art therapist work in, it is very possible that BPD has often remained undiagnosed, particularly if those settings do not have a medical/psychiatric component. Additionally Franks and Whitaker (2007) questioned whether art therapists were comfortable working with diagnostic categories and the BPD diagnosis perhaps more than others. It is possible then there may be substantial underreporting of this condition in art therapy literature. However, in 2005, the Art Therapy Practice Research Network (Huet, Springham, & Evans, 2014) developed and conducted a survey of its 200 members which asked questions about the severity of difficulties the service users attending art therapy had at a specified one week period (Evans, 2007). The questions asked art therapists to rate all the individuals on their case loads from one (no difficulties) to five (extreme difficulties) on the following dimensions: difficulties verbalising; physical health problems; socio-economic difficulties; risk to others; risk from others; risk to self; engaging in relationships; trauma; and end of life. Ninety seven art therapists took part and whilst that figure was not large in relation to the then 1200 members of the British Association of Art Therapists, that figure represented nearly fifty percent of art therapists who had joined the Art Therapy Practice Research Network. A picture of a highly traumatised, socio-economically deprived group who presented a risk to themselves and had great difficulty verbalising was indicated as not only engaging in art therapy, but staying in it: "It is clear that the art therapists in the survey were retaining in treatment even clients they rated as posing substantial challenges for a considerable period of time" (Evans, 2007, p. 17). This description of art therapy service user characteristics shares many common features with the difficulties associated with BPD. Our conversation with art