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Borderline Personality Disorder Psychological Treatment: An Integrative Review

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A B S T R A C T

Borderline personality disorder (BPD) is a complex and at times debilitating mental disorder, treatment of which has eluded effective pharmacotherapy (Gunderson, 2007). Although once considered untreatable, psychodynamic therapy and cognitive therapy (two types of psychological therapies) have provided hope for better lives for patients with this diagnosis (Gunderson). The author performed an integrative review of the literature pertaining to the present role of evidence-based practice (EBP) using the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition, Text Revision* (DSM-IV-TR) definition of BPD to identify symptoms of the disorder. Thirty-eight peer reviewed articles, mostly quasi-experimental, three meta-analyses, two books, and two national psychiatric guideline websites were reviewed. BPD treatment may be successful with a variety of psychological therapies. Application of empirical studies is only part of BPD treatment considerations. Heterogeneous symptom presentation requires much professional interpersonal interaction and the literature is scant on inductive research for BPD. This review is limited to psychological aspects of BPD treatment.

Human behavior has been studied for hundreds of years and various health professions have explored personality variables which cause mental distress. One of the newer psychiatric diagnoses is borderline personality disorder (BPD). The American Psychiatric Association (2010) has published standard nomenclature of emotional illnesses in a manual called the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition, Text Revision* (DSM-IV-TR). Borderline personality disorder is one of the DSM-IV-TR medical diagnoses. BPD is medically diagnosed by the existence of at least five of nine symptomatic criteria. These are: (a) fears of abandonment; (b) unstable interpersonal relationships; (c) unstable sense of self; (d) impulsivity, which is potentially self damaging; (e) parasuicidal behavior or self mutilation; (f) affective instability; (g) chronic feelings of emptiness; (h) inappropriate anger; and (i) transient paranoid ideation or dissociative symptoms (American Psychiatric Association, 2010). However, this diagnosis does not fully describe the heterogeneity, and at times emotionally painful continuum of living with this mental illness (Bornovalova, Gratz, Levy, & Lejuez, 2010; Gunderson, 2009; Holm & Severinsson, 2008).

The community prevalence of borderline personality disorder is estimated to be between 1.4% and 5.9% (Lenzenweger, Lane, Loranger, & Kessler, 2007) and exists across cultures (Phillips, Yen, & Gunderson, as cited in Townsend, 2006). Despite its prevalence, the core psychopathology and related neurobiology remain unknown (Gunderson, 2009). Recent medical findings point to consideration of the complex neurochemical issues found in this disorder in addition to symptoms.

The public health costs to patients, families and communities are unknown and occur in many areas including use of psychiatric services, medical costs associated with behavior manifestations, divorces, and use of other public services (Gunderson, 2007; Gunderson, 2009).

These costs highlight the importance of studying current treatment therapies. Borderline personality disorder has no well defined, pharmacological treatment specific to diagnosis of BPD, psychosocial interventions remain a cornerstone of treatment (Gunderson, 2009), the present role of evidence-based practice is still evolving (Tannenbaum, 2006; Weitz & Addis, 2006). Mental health professionals may wish to consider inductive research findings for this disorder.

A philosophical underpinning of care which some mental health treatment programs have adopted is the Tidal model of mental health recovery (Barker & Buchanan-Barker, 2008). Although not specific to any particular mental illness, the Tidal model's values reflect how others might wish to be treated when in distress (Brookes, 2006). The Tidal model of mental health recovery, a quality improvement organization of philosophical underpinnings (Barker & Buchanan-Barker, 2008; Berger, 2006; Brookes, Murata, & Tansey, 2008; Swift, 2009), may provide an alternate philosophy, different from the medical diagnostic model, from which to organize mental health care. The ten essential values which underpin the Tidal model are: (a) valuing the person's story, (b) respecting the person's linguistic style, (c) developing genuine curiosity, (d) becoming an apprentice, (e) revealing personal wisdom, (f) being transparent, (g) using the person's experiences as tools, (h) crafting the step beyond the present distress, (i) giving the gift of time, and (j) knowing that change is constant (Brookes, 2006). The

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Tidal model has been found to decrease numerous public safety concerns in mental health treatment programs (Brookes et al., 2008) and is congruent with the BPD treatment therapies which will be mentioned. This paper will review the current literature on a BPD theory of development, treatment therapies, and the present role of evidence-based practice. Discussion and conclusions for mental health professionals will follow.

METHODS

CINAHL, and PsycARTICLES, databases were searched for articles on the subject of psychological treatment efficacy for BPD, which revealed thousands of references. Limiting the searches to the last five years still produced over one thousand references. Hand searches of selected article bibliographies allowed refinement of topic details. The Cochrane Database did not reveal any systematic reviews on efficacy of psychological BPD treatments from 2006 to 2011. Keyword searches, limited to peer reviewed professional journals in the last five years, resulted in 200 articles overall, of which, 38 were reviewed. Those articles which were eliminated mentioned BPD along with many other psychiatric disorder treatments without the results being separated by DSMIV-TR diagnosis. Articles which discussed various aspects of BPD or treatments specific to the disorder were included as were some which discussed alternative behavior groupings sharing some similarities to the mental distress experienced by those with the BPD diagnosis. Three meta-reviews covering specialized aspects of BPD met the inclusion criteria. The websites of the United States Department of Health and Human Services, Agency for Healthcare Research and Quality, and of the American Psychiatric Association were also reviewed. In addition, two mental health books, *Evidence-Based Psychotherapy* (2006) and *Essentials of Psychiatric Mental Health Nursing* (Townsend, 2006) were also reviewed for this paper.

BPD THEORY OF DEVELOPMENT

Mu-Receptor Findings

The complex behavioral disorder diagnosed as BPD does not have a known cause, however, biosocial and neurochemical theories are undergoing research (Gunderson, 2009; New & Stanley, 2010; Stanley & Siever, 2010). Stanley and Siever (2010) reported that patients with BPD, who self-injure, have decreased endogenous opioids, especially beta-endorphins and met-enkephalins (Stanley et al., 2010) and also found an association between a mu-opioid gene polymorphism and BPD. Prossin, Love, Koeppe, Zubieta, and Silk (2010) studied BPD patients and healthy controls and demonstrated that during neutral social stimulation, the BPD patients had more mu-opioid binding sites in the acumbens (reward center), and the amygdala, whereas the control subjects had more binding sites in the thalamus. During sad emotional states, mu-opioid receptor neurotransmission was greater in BPD patients than in control subjects. They discussed that enhancement of endogenous opioid availability was found to be greater in BPD patients during sad moods than in controls in that study. Thus, the opioid-deficit model was proposed, that self–injurers learn to cut themselves, thereby releasing endogenous opioids which stimulate the reward center (New & Stanley, 2010, p. 883). The study is significant in showing specific sites of neurochemical changes in BPD patients (New & Stanley, 2010). The study authors also report that there is a social behavior role which implicates mu-opioid receptors in regulation of emotional and stress responses (New & Stanley, 2010).

Clinical implications discussed by New and Stanley (2010) are significant. The normal mu-opioid receptor mediated rewards experienced by normal subjects during infant attachment elude BPD patients, because they may be *hard-wired* differently due to high heritability of the disorder (New & Stanley, 2010, p. 884). If BPD patients "do not have sufficient endogenous opioids, then the continual craving for relationships and heightened reaction to their loss is understandable," (New & Stanley, 2010, p. 884).

The mu-receptor and endogenous opioid deficit research could impact treatment of BPD enormously. The frustration of therapists in treating BPD and the stigma of diagnosis could be diminished if a neurochemical cause could be found (New & Stanley, 2010, p.884). Potentially pharmacotherapy could be investigated based on any relevant findings as well.

Diagnostic Bias

Although diagnosed in women more than men, by a 3:1 ratio, Bjorklund (2006) found that there is no significant difference in the number of men and women with BPD diagnosis. Lahey (2009) reviewed that neuroticism, a Freudian term sometimes used to describe BPD symptoms, and a construct for worry, anger, sadness, hostility etc. is heterogeneous with no gender predisposition. Lahey's paper looked at several mental disorders including BPD in the broader context of neuroticism, thereby limiting generalization to BPD. Bjorklund explored the literature concerning the greater number of women diagnosed with BPD than men and found hierarchical power, and other cultural factors promoted diagnostic bias. Recognition of this is important when drawing conclusions based on gender for this complex illness. Wood and Tracey (2009) studied the presence of diagnostic overshadowing, that is when one diagnosis overshadows and diminishes recognition of additional diagnoses. Conclusions were that diagnostic overshadowing was prevalent in the sample studied but could be minimized with additional feedback training. Since the diagnosis of BPD is based purely on behavioral criteria, recognition of the possibility of diagnostic overshadowing may limit validity of empirical studies, a cornerstone of EBP.

TREATMENT THERAPIES

Treatment efficacy encompasses psychosocial therapies including psychodynamic and dialectical treatments (Harvard Medical School, 2006). Both of these are important to consider in treating BPD. The literature shows evidence for effectiveness of both types of therapy for BPD and is inconclusive about which may be the most important. Because of the process orientation of BPD, examination of a deterioration model is presented, and a less extensively documented alternative way to organize treatment is mentioned with latent class analysis as the diagnostic focus.

Psychodynamic Therapy

Leichsenring and Leibing (2003) did a meta-analysis of the effectiveness of two types of psychological therapy commonly used for treatment of BPD. The meta-analysis compared the effectiveness of psychodynamic based psychotherapy and cognitive based therapy for personality disorders. The Leichsenring and Leibing meta-analysis is the most recent, and reported both psychodynamic and cognitive therapies as being effective long term. In another study done by Leichsenring and Leibing (2004), psychodynamic therapy was reported as being effective therapy in the short term. A limitation of the 2004 Leichsenring and Leibing study is its discussion about the broad category of personality disorders.

Additional psychodynamic treatment considerations are whether patients with other psychological co-morbidities should be included in empirical study samples and whether DSM-IV-TR symptom remission is the best way to study and treat BPD patients (Gunderson, 2009; Stone, 2010). The literature was inconclusive about inclusion of co-morbidities in studies of BPD.