



## 7 - PSYCHOTHERAPY OF BORDERLINE PERSONALITY DISORDER

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### **Abstract**

*Borderline personality disorder (BPD) is both a common and serious psychiatric disorder, associated with high level of psychiatric care and high levels of psychosocial impairment. The individuals with this disorder can have negative and distorted views of themselves, along with feelings of low self-worth; they might easily become argumentative, moody and impulsive. SSRI may be a good pharmacotherapy for BPD, but psychotherapy is considered the primary treatment for this personality disorder. The aim of this paper is to describe the basic treatment strategies used in DBT.*

*There are two psychotherapeutic approaches that have been shown to have efficacy in randomized controlled trials: psychoanalytic/psychodynamic therapy and dialectical behavior therapy. Dialectical behavior therapy (DBT) is a cognitive-behavioral approach to treating borderline personality disorder, developed by Marsha Linehan.*

**Keywords:** *borderline, personality disorder, behavior dialectical therapy.*

### 1. INTRODUCTION

Borderline personality disorder is the most common personality disorder in clinical settings; it causes marked distress and impairment in social, occupational and role functioning, and it is associated with high rates of self-destructive behaviour (e.g., suicide attempts) and completed suicide (APA, 2010). The essential feature of borderline personality disorder is a pervasive pattern of instability of interpersonal relationships, affects, and self-image, as well as marked impulsivity that begins by early adulthood and appears in a variety of contexts (APA, 2010). Common features of borderline personality disorder are a severely

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impaired capacity for attachment and predictably maladaptive behaviour in response to separation.

The prevalence of borderline personality disorder is estimated to be about 6% in primary care settings, about 10% among individuals seen in outpatient mental health clinics and about 20% among psychiatric inpatients (DSM-5, 2013). It is about five times more common among first degree biological relatives of those with the disorder than in the general population.

Borderline personality disorder is diagnosed predominantly in females and often co-occurs with depressive or bipolar disorder. In borderline personality disorder, stress may be a contributing factor in the disorder's aetiology and a precipitant of symptomatic exacerbation (Paris, Zelkowitz, Guzder, Joseph, Feldman, 1999).

## **2. ASSESSMENT OF BORDERLINE PERSONALITY DISORDER**

A comprehensive evaluation of borderline personality includes assessing the presence of co-morbid disorders, degree and type of functional impairment, needs and goals, intra-psychic conflicts and defences, developmental progress and arrests, adaptive and maladaptive coping styles, psychosocial stressors, and strengths in the face of stressors (APA, 2010).

The clinical interview for diagnosing borderline personality disorder should be complemented by knowledge of the DSM criteria and a longitudinal view of the clinical picture (APA, 2010).

When assessing a patient with borderline personality disorder, the clinician should carefully look for the presence of risk-taking and impulsive behaviours, mood disturbance and reactivity, risk of suicide, risk of violence to persons or property, substance abuse, the patient's ability to care for himself/herself or others, financial resources, psychosocial stressors, and psychosocial supports. Suicidal threats, gestures, and attempts are very common among patients with borderline personality disorder, and 8%–10% commit suicide (APA, 2010).

Self-report instruments and clinician-administered rating scales can aid clinicians in identifying, quantifying and tracking change in many of the characteristics we are most interested in, such as quality of life, depression, anxiety or personality style (Baer, Blais, 2010).

Screening tests are assessment tools designed to identify the presence or absence of a target disorder or condition (such as personality disorder or cognitive impairment); they are similar to diagnostic instruments like structured diagnostic interviews (such as the SCID II), but are briefer and typically less precise.

### **3. DIALECTICAL BEHAVIURAL THERAPY FOR BORDERLINE PERSONALITY DISORDER**

Two psychotherapeutic approaches have been shown to have efficacy in randomized controlled trials: psychoanalytic/psychodynamic therapy and dialectical behaviour therapy. Treatment planning should address co-morbid disorders from axis I (e.g., mood disorders, substance-related disorders, eating disorders, PTSD, other anxiety disorders, dissociative identity disorder, and attention-deficit/hyperactivity disorder) and axis II as well as borderline personality disorder, with priority established according to risk or predominant symptoms (APA, 2010).

The dialectical behaviour therapy for borderline personality disorder was developed by Marsha Linehan (1993) as an integrative cognitive-behavioural treatment. The dialectical behaviour therapy aims to reframe suicidal and other dysfunctional behaviours as part of the patient's learned problem-solving repertoire and to focus therapy on active problem solving. This is one of the few psychosocial interventions for BPD that have controlled, empirical data supporting its actual effectiveness (Munroe-Blum & Marziali, 1987; Clarkin, Marziali & Munroe-Blum, 1991). The treatment has three key features: weekly meetings with an individual therapist, one or more weekly group sessions and meetings of therapists for supervision.

The dialectical behaviour therapy is based on a biosocial theory of personality functioning which considers that BPD is primarily a dysfunction of the emotion regulation system resulted from biological irregularities combined with certain dysfunctional environments (Linehan, 1993). The borderline individuals are emotionally vulnerable – including high sensitivity to emotional stimuli, emotional intensity and slow return to emotional baseline, as well as deficient in emotion modulation skills. Linehan (1993) suggests that “treatment should focus on the twin tasks of teaching the borderline patient (1) to modulate extreme emotionality and reduce maladaptive mood-dependent behaviours, and (2) to trust and validate her own emotions, thoughts, and activities”.

The main idea of DBT is that there are thinking biases implicit in maintaining specific problematic emotions and behaviours. The therapist should help the patient identify these extreme and absolute thought patterns and assist him to find alternative, more useful ones. Linehan (1993) concluded that problematic thinking patterns targeted in both DBT and cognitive therapy are as follows:

1. Arbitrary inferences;
2. Overgeneralizations;
3. Magnification and exaggeration of the meaning or significance of events;
4. Inappropriate attribution of all blame and responsibility for negative events to oneself;
5. Inappropriate attribution of all blame and responsibility for negative events to others;
6. Name calling or the application of negative trait labels that add no new information beyond the observed behaviour used to generate the labels.
7. Catastrophizing;
8. Hopeless expectancies or pessimistic predictions based on selective attention to negative events in the past or present.

#### **4. BASIC TREATMENT STRATEGIES**

The basic treatment strategies in DBT are grouped into four major categories: dialectical strategies, core strategies, stylistic strategies and case management strategies.

Dialectical strategies view reality as a holistic process in a state of constant development and change. The dialectical focus of the therapist involves two levels of therapeutic behaviour: the therapist is alert to the dialectical tensions and balance occurring within the treatment relationship itself and teaches and models dialectical behaviour patterns.

The main core strategies are as follows (Linehan, 1993):

1. Emotional validation strategies: providing opportunities for emotional expression, teaching emotion observation and labelling skill, reading emotions, communicating the validity of emotions;
2. Behavioural validation strategies: teaching behaviour observation and labelling skill, identifying the “should”, countering the “should”, accepting the “should”, moving to disappointment.
3. Cognitive validation strategies: eliciting and reflecting thoughts and assumptions, discriminating facts from interpretations, finding the “kernel of truth”, acknowledging “wise mind”, respecting differing values.
4. Cheerleading strategies: assuming the best, providing encouragement, focusing on the patient’s capabilities, contradicting/modulating external criticism, providing praise and reassurance, being realistic, but dealing directly with fears or insincerity, staying near.

Stylistic strategies focus on how the therapist uses other treatment strategies, rather than on the content of communication and there are two primary communication styles in DBT: the reciprocal communication style, defined by responsiveness, self-disclosure, warmth and genuineness and the irreverent communication style, which is unhallowed, impertinent, and incongruous. Reciprocity and irreverence must be woven together into a single stylistic fabric, the styles must balance each other.

Case management strategies focus on how the therapist responds to other professionals; family members and significant others of the patient and provide guidelines for how to apply dialectical, validation and problem-solving strategies to case management problems.

## **5. CONCLUSIONS**

Long-term follow-up studies of treated patients with borderline personality disorder indicate that early adulthood is often characterized by chronic instability, with episodes of serious affective and impulsive dyscontrol, but later in life, a majority of individuals attain greater stability in social and occupational functioning (APA, 2010). A study conducted by Stone (1990) concluded that about one-third of patients with borderline personality disorder had recovered by the follow-up evaluation, having solidified their identity during the intervening years.

Transference-focused psychotherapy (TFP) has proven to be a remarkably successful approach for borderline personality disorder, that effectively targets the pathology of character (Clarkin, Yeomans, Kernberg, 2006; Yeomans, Clarkin and Kernberg, 2015). The primary goal of TFP is to reduce symptomatology and self-destructive behaviour through the modification of representations of self and others as they are enacted in the here and now transference (Zanarini, 2009).

Further controlled treatment studies of other forms of cognitive behaviour therapy are needed, particularly in outpatient settings.

Comprehensive, long-term psychotherapy can be a useful form of treatment for those with BPD. However, less intensive and less costly forms of treatment need to be developed.

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## 6. REFERENCES

- American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)*. Washington, DC: APA.
- American Psychiatric Association. (2010). *PRACTICE GUIDELINE FOR THE Treatment of Patients With Borderline Personality Disorder*. American Psychiatric Association.
- Baer, L., Blais, M.A. (2010). *Handbook of Clinical Rating Scales and Assessment in Psychiatry and Mental Health*. N.Y: Human Press.
- Clarkin, J. F., Yeomans, F.E., Kernberg, O.F. (2006). *Psychotherapy for borderline personality: Focusing on object relations*. Washington, DC: American Psychiatric Publishing Inc.
- Clarkin, J.F., Marziali, E., & Munroe-Blum, H. (1991). Group and family treatments for borderline personality disorder. *Hospital and Community Psychiatry*, 42, 1038-1043.
- First, M.B., Gibbon, M., Spitzer, R I., Williams, J.B., Benjamin, L.S. (1997). *Structured clinical interview for DSM-IV Axis II Personality Disorders*. Washington, DC: American Press.
- Gunderson, J.G. (2001). *Borderline Personality Disorder: A Clinical Guide*. Washington, DC. American Psychiatric Press.
- Gunderson, J.G., Links, P. S. (2014). *Handbook of Good Psychiatric Management for Borderline Personality Disorder*. American Psychiatric Association.
- Linehan, M. M. (1993). *Cognitive-Behavioral Treatment of Borderline Personality Disorder*. New York: Guilford Press.
- Munroe-Blum, H., & Marziali, E. (1987). Randomized clinical trial of relationship management time-limited group treatment of borderline personality disorder. Unpublished manuscript. Hamilton, Ontario Mental Health Foundation.
- Paris, J., Zekowitz, P., Guzder, J., Joseph, S., Feldman, R. (1999). Neuropsychological factors associated with borderline pathology in children. *J Am Acad. Child Adolesc. Psychiatry*; 38:770–774.
- Phillips, K.A., Gunderson, J.G. (1999). Personality disorders, in *The American Psychiatric Press Textbook of Psychiatry*, 3rd ed. Edited by Hales, R.E., Yudofsky, S.C., Talbott, J.A. Washington, DC, American Psychiatric Press, 1999, pp 795–823.
- Stone, M.H. (1990). *Long-Term Follow-Up Study of Borderline Patients: The Fate of Borderlines*. New York: Guilford.
- Zanarini, M.C. (2009). Psychotherapy of borderline personality disorder. *Acta Psychiatr. Scand* 120:373-377.
- Yeomans, F.E., Clarkin, J.F. and Kernberg, O.F. (2015). *Transference-Focused Psychotherapy for Borderline Personality Disorder. A Clinical Guide*. American Psychiatric Association