The development of a psychoanalytically-orientated day hospital treatment for borderline personality disorder: theory, problems, and practice.

Dr Anthony W Bateman, Consultant Psychiatrist in Psychotherapy, Barnet, Enfield, and Haringey Mental Health Care Trust & Honorary Senior Lecturer Royal Free and University College Medical Schools [1]

[1] Address : The Halliwick Unit, St Ann's Hospital, St Ann's Road, London N15 3TH

In this paper, I will discuss some general problems of research into personality disorder (PD), outline some of the difficulties faced in organizing research into borderline personality disorder (BPD), and finally summarize the results of the first randomized controlled trial of outcome of treatment of BPD in Britain (Bateman & Fonagy, 1999; Bateman & Fonagy, 2001)

Borderline personality disorder (BPD) is common, affecting about 1% of the general population and up to 20% of psychiatric in-patients. Approximately 9% of patients eventually kill themselves (Frances, 1986). This fact alone means that finding effective treatment is urgent and yet despite over two decades of research, our knowledge of the disorder and its treatment remains limited. The complexity of the disorder, characterised by 'stable instability', baffles clinicians and researchers alike. Characteristics of impulsivity, self-destructiveness, constant efforts to avoid real or imagined abandonment, chronic dysphoria, sudden anger or boredom, transient psychotic episodes or cognitive distortions, and identity disturbance all mitigate against a smooth ride for researchers and clinicians. It is therefore not surprising that many continue to avoid borderline patients finding them frustrating and impossible. Despite these problems, our unit set out to investigate a psychoanalytically orientated treatment for borderline personality disorder using a randomized controlled design. It soon became

apparent why there was only one other randomized controlled trial of BPD (Linehan, Armstrong, Suarez, *et al*, 1991)!

Problems of outcome research into personality disorder

There are few controlled trials of treatment for BPD. There are a number of reasons for this. Firstly there are problems of case identification and co-morbidity. Although enshrined in diagnostic classifications, concern about the validity of the diagnosis remains. An overlap with affective disorders exists but Gunderson and Phillips (Gunderson & Phillips, 1991) have concluded that the two disorders are not the same although affective instability is at the heart of BPD. Secondly, BPD is an heterogeneous condition and varies in severity. Until recently there was no measure of severity making it impossible to assess the level of morbidity in a sample of patients. Crude attempts to establish severity at the outset of treatment or entry into a trial such as counting acts of self-harm over the preceding weeks or months probably bears little, if any, relationship to severity. A patient who makes serious suicide attempts at infrequent intervals may be more seriously disturbed than a patient who frequently, albeit usually sporadically, takes overdoses. Finally, there is the difficulty of random assignment which has now become the gold standard against which treatments are tested.

Randomisation

Borderline patients do not take kindly to randomisation. Their search is for stability and certainty. Offering them referral into a research project in which their allocation appears to be dependent on the toss of a coin confronts them

with uncertainty and makes them vulnerable to fears of rejection. Both randomisation in and randomisation out causes problems. Borderline patients at the severe end of the spectrum have usually had years of psychiatric treatment and psychotherapy. Each new offer of treatment is a moment of hope. For those accepted into treatment, early expectations may not be met. When confronted with the reality of hard therapeutic work, the result may be, at best, a feeling of demoralisation and, at worst, rage and aggression and refusal to participate in any further aspect of research. Randomisation out of the treatment into a control group can lead to refusal to co-operate. Yet the researcher needs patients who are randomised out of the treatment programme to agree to further interviews and to fill out questionnaires. This can become progressively difficult over time leading to a high attrition rate in a control group, distorting the cohort of patients. Some patients may even take pleasure in ensuring that researchers do not get the information they ask for at the time that it is needed leading to further sampling problems. Given the relatively small cell sizes of RCTs, attrition represents a serious threat to internal validity. PD patients tend to show relatively high attrition rates in treatment trials (Tyrer, Seivewright, Ferguson, *et al*, 1990) although this varies according to personality disorder diagnosis (Shea, Pilkonis, Beckham, *et al*, 1990) and treatment approach(Linehan, Armstrong, Suarez, *et al*, 1991); (Rosser, Birch, Bond, *et al*, 1987); (Bateman & Fonagy, 1999).

In addition to the sampling problems discussed above there are other difficulties. First, there is an accumulating literature on the importance of patient expectations for therapy outcome (Horowitz, Rosenberg & Bartholomew, 1993). Strict randomisation may lead to treatment allocations incongruent with patient expectation and this may be particularly problematic for patients whose lack of

flexibility is almost a defining feature of their disorder (Bleiberg, 1994). Second, RCTs, with notable exceptions (Shapiro, Rees, Barkham, *et al*, 1995), do not randomise therapists to patients even though it is known that the personality, skills and training of the therapist have significant effects on outcome (Beutler, Machado & Neufeldt, 1994). This potential confound is likely to be even greater for psychotherapeutic treatments of PD given that interpersonal relationship problems are undoubtedly at the core of personality disturbance. Third, investigator allegiance (Robinson, Berman & Neimeyer, 1990) has been shown to strongly affect outcome and unbiased, blind evaluations are hard to achieve in long term treatments. Fourth, comparison groups are difficult to identify for long term therapy trials. A no treatment comparison is ethically unacceptable in BPD (Basham, 1986), particularly as suicidality and self harming behaviour are common. On the other hand, as long-term therapy tends not to be routinely available, a treatment-as-usual control group may be valid and appropriate.

There is a trade-off between the internal validity (Cooke & Campbell, 1979) of well-controlled trials, which ensure that causal inferences may be appropriately drawn from experimental manipulations, and the external validity of naturalistic research designs which are limited in terms of causal inference but which generate findings more readily generalisable to everyday practice (Jensen, Hibbs & Pilkonis, 1996) (Hoagwood, Hibbs, Brent, *et al*, 1995). At the extreme end of naturalistic studies are survey reports, such as the consumer survey of psychotherapy (Seligman, 1995). Of course, what is sacrificed in surveys is information about the exact nature of the treatment offered and information from individuals who did not respond. Imposing strict controls, however, carries a cost in depicting psychotherapy in a far more organised and coherent form than is available in the real world of the clinic. No wonder, then, that clinic-based

studies tend to regularly under-perform more strictly performed laboratory-based investigations (Weisz, Donenberg, Han, *et al*, 1995).

But most importantly, the absence of clear distinction between even manualised treatment interventions has contributed to the lack of progress on specifying particular therapeutic approaches BPD. Outcome evaluation is hampered by the lack of specificity in psychological approaches to therapy (Roth, Fonagy & Parry, 1996) and some have argued that the considerable overlap between psychotherapies compromises the possibility of reaching conclusions concerning relative effectiveness (Goldfried, 1995). The problem is, once again, particularly acute in the case of the long-term approaches used in treating personality disorder. With such patients, practitioners make complex choices in selecting interventions that take account of both behavioural and dynamic factors. In order to enhance specificity researchers have "manualised" treatments and developed measures to assess the extent to which therapists are able to follow protocols outlined therein. Three approaches to therapy with borderline personality disorder have so far been manualised. These include psychoanalytic psychotherapy (Clarkin, Kernberg & Yeomans, 1999) ialectical behaviour therapy (Linehan, 1993b), and object relations/interpersonal approaches (Dawson, 1988) (Marziali.E, 1989). The manual for Cognitive-Analytic therapy is as yet untested (Ryle, 1997).

Treatment Intervention

The modified individual psychoanalytic approach adopted by Kernberg (Clarkin, Kernberg & Yeomans, 1999) is based on clarification, confrontation, and interpretation within a developing transference relationship between patient and

therapist. Initially there is a focus and clarification of self-destructive behaviours both within and without therapy sessions. Gradually aspects of the self that are split off from the patient's core identity are challenged, especially as they impinge on chaotic impulsive behaviour, fluctuating affects and identity conflict which itself leads to dissociation. Understanding and resolving their impact on the transference relationship becomes central. Considerable work on elaborating and validating this therapeutic approach has been performed as part of an NIMH funded treatment development project demonstrating that it is possible to train clinicians to use this method (Clarkin, Foelsch, Levy*, et al*, 2001).

In contrast, Linehan's strategy in DBT uses support, social skills, education, contingency management, and alternative problem solving strategies to manage impulsive behaviour and affect dysregulation. A mix of both individual and group psychotherapy is used. However, the relationship between the patient and therapist is pivotal in helping the patient replace maladaptive actions such as self-destructive acts with adaptive responses during crises. Linehan (Linehan, 1993a) suggests that a number of aspects 'set if off from "usual" cognitive and behavioural therapy' and that 'the emphasis in DBT on therapy-interfering behaviours is more similar to the psychodynamic emphasis on "transference" behaviours than it is to any aspect of standard cognitive-behavioural therapies'.

The treatment strategy developed by Dawson (Dawson, 1988) and colleagues is named 'relationship management psychotherapy' (RMP). In essence, this approach conceptualises the borderline patient as struggling with conflicting aspects of the self, leading to instability. Interpersonal relationships, including the therapeutic relationship, become the context in which the patient tries to resolve conflicts through externalisation. For example, if a therapist is

optimistic and active the patient becomes pessimistic and compliant. In some ways such polarities are similar to the reciprocal roles identified in cognitive analytic therapy. The task of the therapist's role is to alter the rigidity of the dialogue and to disconfirm the patient's distorted experience through attention to the process of sessions rather than the content of the interaction. The format is exclusively through time-limited group psychotherapy.

At first sight these three methods may sound distinctly different, ranging from individual therapy to a mix of individual and group therapy to solely group psychotherapy. Beyond that there are some striking similarities. Both Kernberg and Linehan focus initial sessions on the establishment and negotiation of a treatment contract within the framework of their approach. A particular emphasis is placed on self-destructive behaviour, especially therapy interfering behaviour, and appropriate limits are set and renewable contracts made. Both methods carefully define the responsibilities of the therapist on how self-destructive behaviour will be handled, regular appointments are arranged, and acceptance of difficulties of remaining in treatment are recognised and explicit statements made about the possibility of failure of treatment. Identity issues are central from a psychoanalytic viewpoint and therapists are constantly on the alert for split-off aspects of patients and how these are played out in the patient-therapist relationship. In DBT there is less emphasis on identity issues but nevertheless a 'black-and-white' cognitive style is targeted through dialectical techniques to help the patient overcome the all-or-none thinking and polarised approach to life. Both treatments prescribe the level of contact permissable between patient and therapist. In DBT, emergency sessions are allowed to enable the therapist and patient to develop alternative ways of crisis resolution other than hospital admission or self-destructive behaviour. In psychoanalytic

therapy contact between sessions is not permitted although discussion of alternative routes to support between sessions may be a focus of a consultation. Implementation of the two treatments is consistent with theoretical views. Linehan provides information about cognitive-behavioural conceptualisation of self-destructive behaviour whilst Kernberg uses exploratory interpretations using ideographic hypotheses relating self-destructive behaviours to feelings about treatment. Both discuss alternative pathways to resolution of conflict and distress.

In contrast to these overlaps, RMP takes a more neutral stance. No formal contract is made, no attempt is made to interpret or to explain the patient's anger or self-destructive behaviour, and no emphasis is given to education or understanding about actions or threats that may disrupt therapy. Instead, the primary therapeutic task is to identify 'core messages' that reflect the polarities of conflict about which the patient is struggling. Therapists generate hypotheses about these as they are played out in the group setting whilst avoiding enacting any of the externalised, polarised selves. On theoretical grounds, it may be supposed that this is the least supportive therapy for borderline patients and likely to lead to early drop out or failure to take up offer of treatment whilst DBT is the most supportive given its methods and the availability of the therapist. Whilst there is no data on the drop-out rate for RMP, Linehan has shown that the drop out rate is low in DBT (16%). Whilst the drop out rate for psychoanalytic therapy is reportedly higher, it may be altered. We (Bateman & Fonagy, 1999) had an attrition rate of only 12%.

The marked overlap between therapies for long-term treatment of personality disorder has significant implications for research since randomised comparison

of one intervention with another sits uppermost in a hierarchy of stringent tests for any treatment. Not only may this control for many processes independent of the treatment and common to all psychological treatments but also may include tests between specific competing mechanisms. But 'horse-race' comparative studies in long term treatment are unlikely to be helpful in identifying better methods of treatment since there is so much variance within each treatment and overlap between them that differential treatment effects are likely to be masked. It is more important to isolate the effective aspects of different treatments (Waldinger & Gunderson, 1984). It remains unclear a decade on what the effective components of DBT are. The original and unreplicated study was from a university department using highly trained and supervised therapists with enthusiasm and motivation implementing a new approach. Whether this can be generalised using less trained personnel working in community teams remains to be seen. Davidson and Tyrer (Davidson, 1996) remark that the translation of such a complex treatment into limited resource settings such as community mental health centres is questionable given the many therapist hours and requirement for expert supervision. Of course, this issue is not peculiar to DBT and psychoanalytic treatments are probably poorly generalisable.

Conclusions from research

In the light of the considerable problems which still exist in conceptualising and defining borderline personality disorder, separating it from other mental disorders, and designing treatment trials of long term therapy (which have adequate internal as well as external validity), it is perhaps not surprising that our knowledge concerning effective psychological treatments of BPD seems still to be somewhat rudimentary. Effective treatment protocols are relatively few in

number and even where they exist remain largely untested. However, studies consistently demonstrate modest gains associated with relatively high doses of treatment. There is also encouraging evidence that these gains are cost effective (Gabbard, Lazar, Hornberger, *et al*, 1997) (Stevenson, 1999), particularly in terms of savings in health care costs.

Halliwick Psychotherapy Unit – research and its implications

Our research demonstrates many of the problems that are outlined above. Both its strengths and weaknesses arise from the fact that it is clinical service research resulting in a trade-off between internal and external validity. On the positive side, firstly the programme was developed and implemented by a team of generically-trained mental health professionals with an interest in psychoanalytically orientated psychiatry rather than by highly trained personnel within a university research department. Secondly, the research took place within a normal clinical setting and in a locality and healthcare system in which patients were unlikely to be able to obtain treatment elsewhere. The latter allowed effective tracing of patients within the service and accurate collection of data about psychiatric hospital admission. Thirdly patients were treated at only two local hospitals for medical emergencies such as self-harm, enabling us to obtain highly accurate data of episodes of self-harm requiring medical intervention. On the negative side, the programme was complex, leading to difficulty in being able to identify the effective ingredients should this be the result. It was also unfunded. However, the programme was designed so that it could be dismantled at a later date to determine the potent ingredients. At present a randomised controlled trial is underway of an out-patient treatment

package made up of three of the ingredients that we consider to be the effective components of the programme.

In developing the research programme, we were joined by Peter Fonagy whose theoretical ideas and knowledge of research were pivotal in identifying a coherent treatment programme (Fonagy, Kennedy, Leigh, *et al*, 1992). Our initial tasks were to review the literature, to consider the evidence for effective interventions, and to match those to the skills within the team. We concluded that treatments shown to be effective with BPD had certain common features. They tended (a) to be well-structured, (b) to devote considerable effort to the enhancing of compliance, (c) to be clearly focussed, whether that focus was a problem behaviour such as self-harm or an aspect of interpersonal relationship patterns, (d) to be theoretically highly coherent to both therapist and patient, sometimes deliberately omitting information incompatible with the theory, (e) to be relatively long term, (f) to encourage a powerful attachment relationship between therapist and patient, enabling the therapist to adopt a relatively active rather than a passive stance, and (g) to be well integrated with other services available to the patient. While some of these features may be those of a successful research study rather than those of a successful therapy, we concluded that the manner in which treatment protocols were constructed and delivered was probably as important in the success of treatment as the theoretically-driven interventions.

With these general features in mind, we set about developing a programme of treatment and organising a research programme to test the effectiveness of the intervention. From the outset it was clear that this was to be ‘effectiveness research’ rather than ‘efficacy’ research – we would investigate the outcome of

BPD treated by generically-trained but non-specialist practitioners within a normal clinical setting. In this way, the treatment was more likely to be translatable to other NHS services without extensive and expensive additional training of personnel. But first we had to define a psychoanalytic view that was understandable to both staff and patients, second ensure that this enabled staff to think about any clinical situation that might arise, and finally, define how to react in a consistent manner to common situations such as suicide threats and acts of self-harm.

Psychotherapy , BPD, attachment and mentalizing

Psychotherapy, in all its incarnations, is about the rekindling of mentalization. Whether we look at Marsha Linehan's dialectic behaviour therapy protocol, John Clarkin's and Otto Kernberg's recommendations for psychoanalytic psychotherapy, or Anthony Ryle's cognitive analytic therapy, they all: (1) Aim to establish an attachment relationship with the patient, (2) Aim to use this to create an interpersonal context where understanding of mental states becomes a focus; (3) Attempt (mostly implicitly) to recreate a situation where the self is recognized as intentional and real by the therapist and this recognition is clearly perceived by the patient.

The core of our treatment programme for BPD is to a) help the patient understand and label emotional states with a view to strengthening the secondary representational system; b) enhance reflective processes; c) to focus on brief, specific interpretation, initially avoiding a focus on aggression. Enhancement of reflective processes enables the development of stable internal representations and the formation of a coherent sense of self. Care about interpretation is

important. For example, the inevitable destructiveness of these patients in relation to the therapeutic enterprise is rarely adequately dealt with by confrontation or interpretations of their aggressive intent. Such attacks are best regarded as self-protective.

Gaps in mentalization in BPD engender impulsivity and, during treatment, the intensification of the therapeutic relationship highlights the patient's difficulties and further exposes the rift between internal and external reality. This stimulates enactments. Attempts to bridge this dissociated mode of a patient's functioning, where nothing feels real (certainly not words or ideas) to moments when words and ideas carry unbelievable potency and destructiveness, can seem an awesome task. The therapist's concern is in some way analogous to that of the parents who create a frame for pretend play -- except in this case it is thoughts and feelings that need to become accessible through the creation of a transitional area. The therapist must get used to working with precursors of mentalization. The task is the elaboration of teleological models into intentional ones (Dennett, 1987). Yet it is only by being able to become part of the patient's pretend world, trying to make it real, while at the same time avoiding entanglement with the equation of thoughts and reality, that progress becomes conceivable. In our view, this process is best done within a transference-countertransference relationship but by a team of professionals rather than by an individual working alone because of the severe difficulty in avoiding destructive entanglements.

Transference

Whatever the approach taken to the treatment of BPD, problems of transference and countertransference are inevitably present and need to be planned for. Even

in DBT, supervision takes into account the feelings engendered in the therapist by that patient and how such feelings can distract the therapist from his task. But should the psychoanalytic therapist work in the transference with borderline patients?

The transference of early relationship patterns onto current relationships, while ever present, is rarely helpful to highlight. Without mentalization, which acts as a buffer between internal and external reality, transference is not displacement but is experienced as real. If the therapist is experienced as an abuser he is the abuser -- no "as-if" about it. When such transference interpretations are made, the patient is often thrown into confusion and to protect the therapy has no choice but to enter a pretend mode in which their subjective experience has no relationship to what is perceived by the therapist as reality (Fonagy & Target, 1996). Gradually patient and therapist may elaborate a world, which however detailed and complex, has little experiential contact with anything that feels real. In our view transference interpretation has to be more circumspect and is best dismantled into small parts that build up over time in an incremental way. For example, a simple acknowledgement of affect in the here and now, while conveying in words, tone and posture that the therapist is able to cope with the patient's emotional state may be the most productive line initially. Generic transference interpretation should only be used, if ever in its raw form, only late in treatment. Transference, using the term in its broadest sense, is helpful as a concrete demonstration of alternative perspectives. The contrast between the patient's perception of the therapist as she or he is imagined and as she or he actually is may help to place quotation marks around the transference experience.

Some programmes attempt to control enactments by making therapy contractually dependent. In our day hospital and out-patient programme we do not make 'therapy dependent' contracts. To do so risks discharging the patient for the very problems for which they are being treated. Being modest in one's aims is the most helpful device. One should not hope that insight through interpretation of transeference will prevent enactment; the aim is simply the gradual encouragement of mentalization. Consequently, the interpretation of enactments is rarely as helpful as trying to deal with their antecedents and consequences. We need to be equally permissive about our own tendency to enact in the countertransference. We have to accept that in order for the patient to stay in mental proximity we have to become what they need us to be. Yet we know that if we become that person, we can be of no help to them. Our aim should be the achievement of a state of equipoise between the two - allowing oneself to do as required yet trying to retain in our mind as clear and as coherent an image of the state of the mind of the patient as we are able to achieve.

Split transference

One of the most complicated challenges arising from treating BPD relates to externalisations of unbearable self-states. Splitting the transference by creating alternative foci for the patient's feelings is important here. In our programme the transference is split in a number of ways. Firstly, a package of group and individual therapy splits the transference and allows the patient to reflect on himself in the group during the individual session. Secondly, patients with BPD commonly have severe social problems or trouble with the law and so an additional member of the team is appointed to help them deal with these

practical realities whilst the individual therapist focuses on the relationship problems, unencumbered by practical issues.

So, what are the hallmarks of a successful therapy with an individual with severe borderline features?

No theory gets anywhere close to explaining the complex problems of this group of patients. However, having a theoretically coherent approach is vital. Such patients require that we are predictable and our implicit working models of them can then begin to form the core of their self-representations. A stable, coherent image is impossible to maintain, should the therapist swap theoretical approaches at an alarming rate. Mentalization can only be acquired in the context of an attachment relationship. This means that the therapy must embody a secure base. Attachment is inseparable from a focus on the mental state of the other. There can be no bond without understanding, even if understanding is possible without a bond. Treatments always take considerable time, and consistency over such prolonged periods is often hard to maintain. The patient is terrified of and actively fights mental closeness, even when physical proximity appears to be his overarching goal. Retaining such proximity while under persistent attack is neither comfortable nor likely to be achieved unless one leaves one's personal sensitivity at the door. Finally, one should be careful not to under-estimate the extent of the patient's incapacity. It is easy and relatively comforting to engage with the representational world of these patients at a level of complexity that they, in reality, have little appreciation of. They are readily seduced into such relationships and accept these complexities within a pretend mode, dramatically removed from anything which feels real to them. Such therapies tend to be durable but they are sadly unhelpful in the long run.

In order to establish consistency within a secure base and to minimise entanglement within transference and countertransference enactments we take a team approach. The team's mentalistic, elaborative stance ultimately enables the patient to find himself in the team's mind as a thinking, feeling being. This allows him to integrate this image as part of his sense of himself. There is a gradual transformation of a non-reflective mode of experiencing the internal world which forces the equation of the internal and external into one in which the internal world is treated with more circumspection and respect and as separate and qualitatively different from physical reality. Even if work were to stop here, much would have been achieved in terms of making behaviour understandable, meaningful and predictable. The internalisation of the team's concern with mental states enhances the patient's capacity for similar concern towards his own experience. Respect for minds generates respect for self, respect for other and ultimately respect for the human community. It is this respect which drives and organizes the therapeutic endeavour within our programme and it is the operationalisation of these ideas that we put to the test.

Research and Results

In the present study, we carried out a randomisation of patients either to treatment in the day hospital programme or to continuing treatment within the general psychiatric service (control group). All patients were assessed using standardised criteria for borderline personality disorder, namely the Structured Clinical Interview for the DSM-III-R (SCID-II) (Spitzer, Williams, Gibbon, *et al*, 1991) and the Diagnostic Interview for Borderlines (DIB) (Gunderson, Kolb & Austin, 1981). A cut off score of 7 or more was used for a formal diagnosis

of BPD. If patients met both criteria for BPD they were selected for randomisation either to treatment in the day hospital programme or to continuing psychiatric treatment. Patients were excluded from the study if they also met DSM-III-R, based on SCID-I criteria, for schizophrenia, bipolar disorder, substance misuse, or mental impairment, or had evidence of organic brain disorder based on SCID-I (Spitzer, Williams, Gibbon, *et al*, 1990). 60 referrals met the criteria for inclusion in the study. 10 refused to participate in the randomisation. 6 of these were admitted to the day hospital programme and excluded from the present study and 4 declined further treatment of any type. 6 further patients did not wish to participate in regular self-assessment and so were also not included. This process of randomisation sounds easy but in fact borderline patients change their mind about research on a regular basis and it becomes increasingly difficult to ensure that patients are clear about their decisions. However, when everything was sorted out there were no significant differences on any of the baseline measures for patients who did not participate in the study compared with those that entered the study. This left 44 patients entering the study who were randomly assigned to the two groups. Within the first month of entering the study, 3 control patients crossed over into the day hospital programme following serious suicide attempts leading to in-patient medical and psychiatric treatment. 3 patients (12%) in the day hospital group dropped out of treatment within 6 months. All were available for follow-up. No subjects dropped out of the control group. Demographic and clinical characteristics of the total cohort of patients are described in the original paper. Following randomisation there was no significant difference on any variable between the two groups including frequencies or average number of axis 1 and axis 2 disorders. Particularly notable was the association of mood and anxiety disorders with BPD.

Treatment in the day hospital condition consisted of: (1) once-weekly individual psychoanalytic psychotherapy, (2) three times per week group analytic psychotherapy lasting an hour each, (3) once a week expressive therapy informed by psychodrama techniques (1 hour), (4) weekly community meeting (1 hour), all spread over 5 days; in addition, on a once per month basis, subjects had (5) a meeting with the case-administrator (1 hour), and (6) medication review by the resident psychiatrist. Therapies and informal patient-staff contact were organised in accordance with a psychoanalytic model of BPD as described above. Medication consisted of antidepressant and anti-psychotic drugs prescribed as appropriate, polypharmacy was discouraged. The maximum length of treatment was set at 18 months.

All therapy was given by psychiatrically trained nurse members of the day hospital team with no formal psychotherapy qualifications. Adherence to therapy was monitored through supervision (twice per week with the whole team) using verbatim session reports and by completion of a monitoring form collecting information about activities and interventions of therapists. Aspects of the day hospital programme have been described elsewhere (Bateman, 1995; Bateman, 1997).

We chose ‘treatment as usual’ in the general psychiatric service as control treatment. This consisted of (1) regular psychiatric review with the senior psychiatrist when necessary (on average twice per month), (2) in-patient admission as appropriate (admission rate 90%, average duration 11.6 days) with discharge to non-psychoanalytic psychiatric day hospital treatment focussing on problem solving (72% attended day hospital with average length of stay of 6

months), followed by (3) outpatient and community follow-up (100%, fortnightly by CPN visits) as standard aftercare. None of the control group received any formal psychotherapy. The initial types and doses of medication were the same for both groups. While this group cannot be considered to have received comparable amount of professional attention to the day hospital group, the approach controls for spontaneous remission.

Measures of outcome

Although we used a series of self-report measures, only the effectiveness of the programme in reducing suicide attempts and other acts of self-harm, decreasing hospital admissions, and ameliorating depression will be considered here.

a) Acts of self-harm and Clinical measures

The criteria for suicidal acts were: 1) deliberate; 2) life threatening; 3) had resulted in medical intervention; 4) medical assessment was consistent with a suicide attempt. Criteria for acts of self-mutilation were: 1) deliberate; 2) resulting in visible tissue damage; 3) nursing or medical intervention required.

A semi-structured interview (Suicide and Self-harm Inventory) was used to obtain details of both suicidal and self-damaging acts for the 6 month period before patients entered the study. This interview asks specific questions not only about numbers of acts but also about dangerousness of acts, i.e. presence or absence of another person, likelihood of being found, preparation, and lethality. Multiple acts over a short period of time, for example a frenzied self-cutting, were counted as a single act. Day hospital patients were monitored carefully

with regard to self-destructive acts and control patients were interviewed every 6 months. Self-reports of suicidal and self-mutilatory acts were cross-checked with medical and psychiatric notes.

For all patients, a search of the hospital in-patient database was made to obtain the number of hospital admissions and the length of stay during a period of 6 months before entry into the study. This was cross-checked with the medical notes. All patients were admitted to the local unit because of the contracted nature of the service. Hospital admission and length of stay and psychiatric day hospital programme attendance was monitored throughout the study for all patients.

Follow-up

An attempt was made at 18 months following admission to follow all 44 patients for an additional 18 months. No patient in the partial hospitalization program was lost to follow-up, but some refused to complete all assessments at all time points. Three patients in the control group refused continued participation. Complete medical records were, however, available for these patients. While assessments were not blind, all the outcome variables were based on objective clinical records confirmed by independent evaluation or were self-report measures.

Details were collected of both suicidal and self-damaging acts at the 24-, 30-, and 36-month evaluations. For all patients, searches of the hospital inpatient database were made at the 24-, 30-, and 36-month evaluations to obtain the

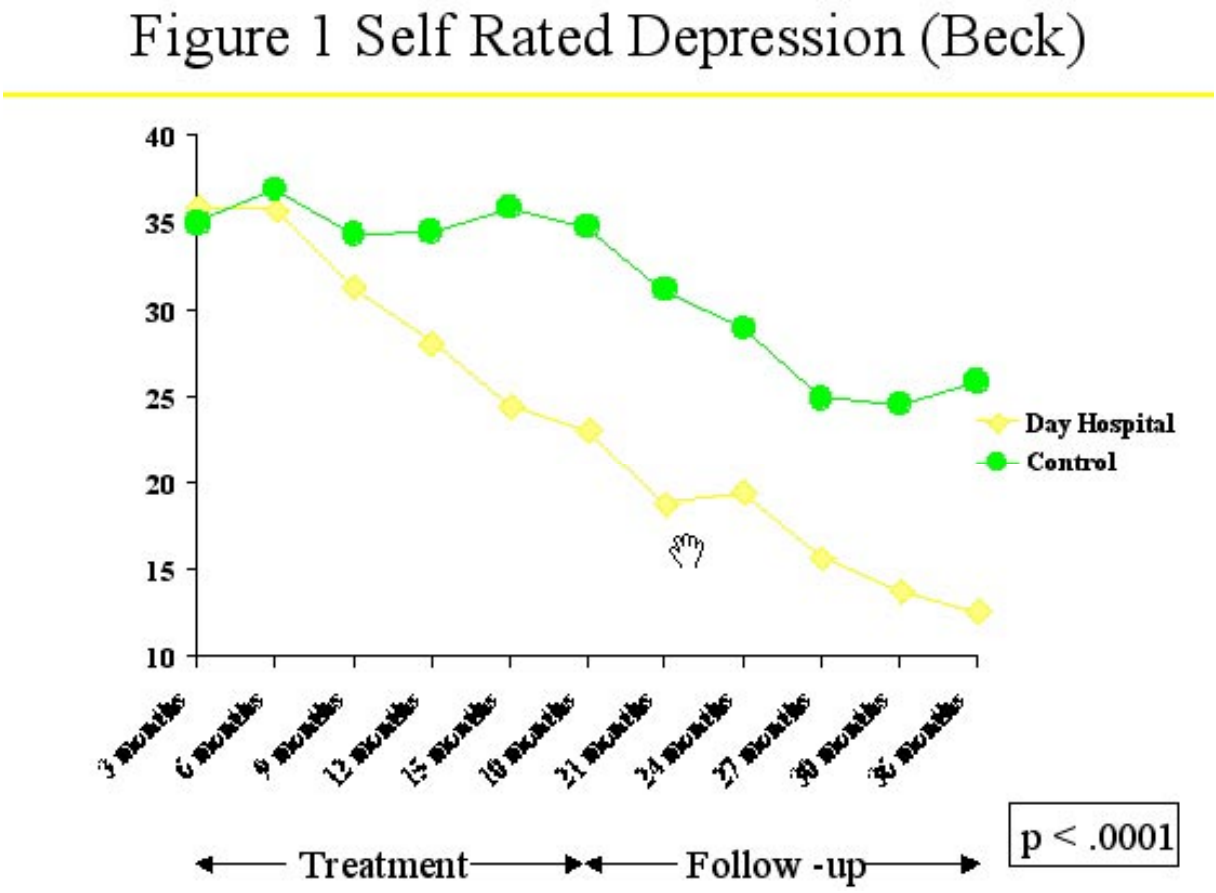
number of hospital admissions and the lengths of stay over the preceding 6 months.

It was not possible to prevent patients having further treatment. Participation in other treatment programs was monitored throughout the study for all patients, including medication data ascertained from prescription charts and dispensing records. A follow-up program was offered to the patients assigned to the partial hospitalization program, which was attended by all except the three who prematurely terminated treatment. The program consisted of group analytic therapy twice a week (180 hours over 18 months) and review in a psychiatric outpatient clinic if requested every 3 months. Group attendance was 75% during the follow-up period, which indicates the stability of this cohort of treated patients. Community centre attendance and general psychiatric partial hospitalization programs were available through self-referral. The control group continued their general psychiatric treatment, which could involve inpatient admission when required, a general psychiatric partial hospitalization program, outpatient consultation, community centre attendance, or medication. None received any formal psychotherapy, although this was not precluded during the follow-up period.

Results

Detailed results can be found in our two published papers (Bateman, 1999; Bateman, 2001) and only some points of particular interest will be discussed here.

Depression (see fig 1) - *Insert figure 1*



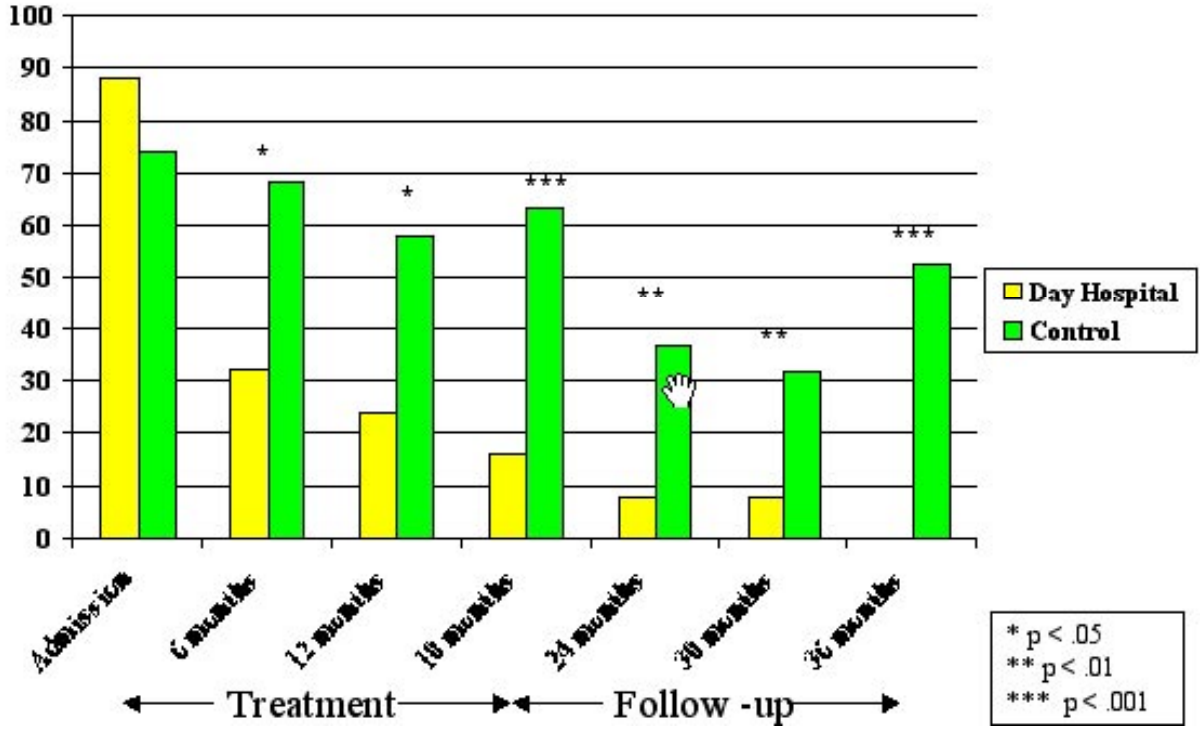
Our treatment programme made little difference to self-reported symptoms of depression as measured by the Beck Depression Inventory (Beck, 1961) for 6 months but following that period a continual decline in depressive symptoms was noted. At discharge only 3 treated subjects and no controls were below the clinical cut point on the BDI. The proportion scoring below 14 increased over the follow-up period to 59% by 18 months in the treated group but only 12.5% in the controls.

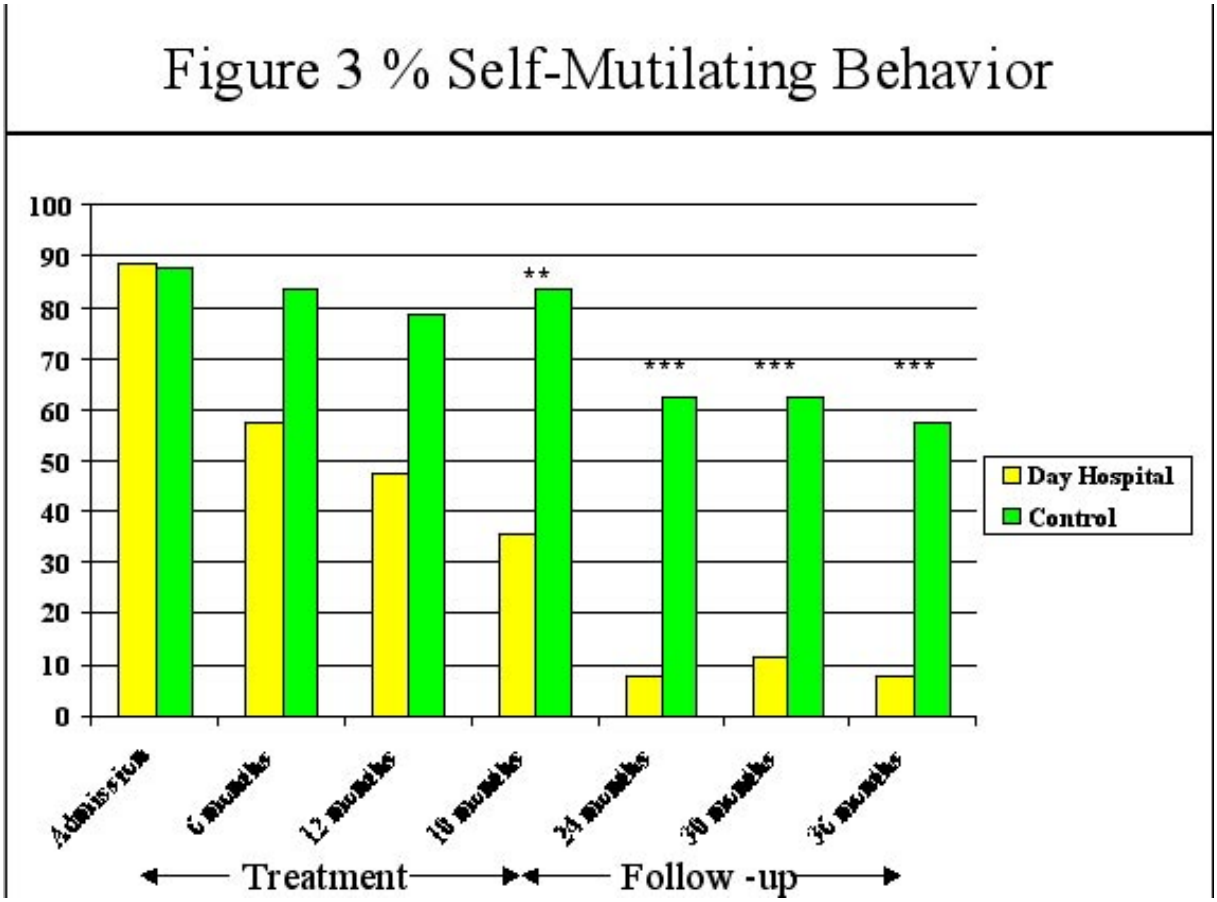
This is in contrast to the RCT of dialectical behaviour therapy in which there were no changes in levels of depression either at the end of treatment or during

follow-up. It seems that the psychoanalytically-oriented programme stimulates rehabilitative effects but a cognitive behavioural programme focusing on symptoms and skills does not. This argument is further supported by the results of suicide and self-harm during follow-up.

Suicide and self-harm (see figures 2 and 3) - *Insert figures 2and 3*

Figure 2 % Attempted Suicide





The continual decline throughout follow-up in suicide attempts and acts of self-harm in the treated group compared with the control group is testament to the rehabilitative effects of the programme. Throughout the study and follow-up period there were no successful suicides in either group and the rapid decrease in suicide attempts during the first 6 months of treatment suggest that simply offering patients a structured, coherent programme of treatment may suffice to reduce their dangerous behaviour. The slower effect on self-harm, with a significant change occurring after 1 year, suggests either that our programme did not focus adequately on such acts (it does not specifically target self-harm alone) or that understanding the meaning of self-laceration in terms of interpersonal and affective contexts takes time to have an effect on such symptoms as a way of dealing with anxiety.

Psychiatric admissions (see Figure 4) - Insert figure 4

The average length of hospitalisation throughout treatment and follow-up, adjusted for pre-admission values, is displayed in Figure X. This confirms that average length of hospitalisation in the control group in the last six months of the study increased dramatically whilst in the PH group it remained relatively stable at around four days per six months. The group-by-time interaction was significant ($F=7.7$, $df=1,35$, $p<.01$), with a highly significant quadratic component ($F=13.3$, $df=1,35$, $p<.001$). The post-hoc test yielded significant differences at 6 months ($t=7.66$, $df=36$, $p<.001$) and 18 months ($t=13.23$, $df=36$, $p<.001$). An identical pattern emerged for number of in-patient episodes ($F = 14.1$, $df = 1,35$, $p<.001$; $F=19.9$, $df=1,35$, $p<.001$ for the two-way and quadratic component of the interaction respectively). In the day hospital group no patient was admitted 6 months after discharge but 1 was admitted for 20 days 1 year after discharge and a further patient was admitted twice in the final 6 months of follow-up for 25 and 12 days respectively. In contrast, in the control group, 7 patients were admitted at least once during the first 6 months after discharge, 7 during the second 6 months, and 14 during the final 6 months. These differences were all significant on Fishers Exact Test ($p<0.002$, $p<0.02$, $p<0.001$ for 6, 12, 18 month time points of follow-up respectively). The average number of days in hospital increased from 6 (SD=10.8, range 0-28) in the first 6 months of the follow-up period, to 12.7 (SD=19.4, range 0-65) in the second, and 15.8 (SD=12.9, range 0-40) in the final 6 months of the follow-up. The differences were significant at all time points on the Mann-Whitney test ($U=143$, $n=41$, $p<0.005$; $U=138$, $n=41$, $p<0.007$; $U=72$, $n=41$, $p<0.001$ for 6,12, 18 months respectively). As there was little variation in the number of hospital days in the

day hospital group we only examined trends in the control group. The repeated measures ANOVA on this group indicated significant differences between time points of assessment (Wilk's Lambda=.644, F=4.18, df=2,16, $p<0.03$). Exploring the polynomial components of this effect confirmed a significant quadratic effect (F=5.60, df=1,17, $p<0.03$) and no significant linear effect ($F<1$, df=1,17, NS).

Conclusions

In the treatment of BPD, effectiveness of treatment can only really be shown though prolonged follow-up. BPD is a relapsing and remitting problem with individuals showing periods of reasonable function followed by episodes of chaos and disorder. Only prolonged follow-up can determine if greater stability has occurred. Our study has one of the longest follow-up periods of a randomised controlled trial of treatment. An uncontrolled study of psychoanalytically orientated treatment by Stevenson and Meares (Stevenson & Meares, 1992; Stevenson & Meares, 1995) has data from a 5-year follow-up. Both follow-up studies show that the initial gains found at the end of treatment are maintained during follow-up. Howard's interesting conceptualisation of psychotherapy into three phases is helpful in understanding this. He suggested that psychotherapy process could be understood as firstly showing a period of remoralization, secondly remediation, and finally rehabilitation. Remoralization or a reduction in distress tends to occur quickly and some of the early changes in our patients such as the fall in general symptom distress were possibly a result of remoralization. Remediation involves refocusing the patients coping skills and helping them see their problems from a different perspective. This is, of course, a major aspect of our programme as we attempt to increase mentalisation and

identification and self-control of affect. It is during this time that patients realise that their problems result from longstanding patterns that are maladaptive and unconsciously determined and that there are no quick fixes. But the real test of treatment is whether or not there are any rehabilitative effects of the programme and this is only determined by follow-up. Do patients who have made gains at the end of treatment maintain those gains? Can they cope with the everyday stresses and strains of life without engaging in their previous strategies of self-harm and so on? Our results suggest that this is the case. Not only are the gains made at the end of treatment maintained, but there are also further improvements. This is particularly clear in the results of depression, suicide attempts and self-harm, and psychiatric admissions.

Whilst the results of our study are encouraging, we neither know why patients improve, nor which patients are likely to benefit most from a psychoanalytically orientated treatment. Further development of psychoanalytic approaches to the treatment of BPD will only come about if we identify more precisely the mechanisms of therapeutic change and we decide on the sequencing of interventions and on whom the interventions are to be carried out. If psychoanalysis is to remain a vibrant and living discipline further research is urgently needed. Only if this takes place will a psychoanalytically based treatment of BPD have a central place in the 21st century.

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