


Mentalization, Borderline Personality Disorder and What works for Whom?

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Treatment for Borderline Personality Disorder

- A range of structured treatment programmes for BPD shown to be effective in RCTs (DBT, TFP, SFT, CAT, MBT) but these are
 - superior mostly against TAU or inadequate comparison AND /OR
 - high maintenance (cost) specialist interventions (extensive training and continued supervision)
- Meaningful trial needs to meet the following minimal criteria:
 - comparison group receiving a **structured treatment** organised in a coherent treatment programme with equivalent supervision
 - delivery of both treatments by professionals **trained to the same level**
 - adequate **statistical power** to detect relatively small differences
 - **representative sample** of clinically referred men and women with confirmed diagnosis of BPD and at high risk of suicide
- The present trial of mentalization based treatment (MBT) was initiated to meet these criteria and reports outcomes after 18 months of treatment.



*Intensive outpatient treatment trial
of MBT (IOP) for BPD patients*



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Mentalizing:

A new word for an ancient concept

Implicitly and explicitly interpreting
the actions of oneself and other as
meaningful on the basis of
intentional mental states

(e.g., desires, needs, feelings,
beliefs, & reasons)



Multiple dimensions of mentalizing in psychodynamic psychotherapy

- Moving from **implicit - automatic** mentalization to **explicit – controlled** mentalization
 - Challenging automatic assumptions
- Elaborating internal representations of mental states of self and others - **external and internal** mentalizing
 - Challenging superficial judgements based on 'appearances'
- Connect feelings with thoughts (**affect and cognition**)
 - Overcoming splitting of affect and cognition (the feeling of feelings)
- Differentiating **self and other** in psychotherapy
 - Adopting the perspective of the other to the self
 - Reducing the impact of the other on the self



Criteria for study (Bateman & Fonagy, in press; Am. J. Psychiat.)

- Inclusion criteria for consecutive referrals to tertiary PD service
 - diagnosis of BPD
 - suicide attempt or episode of life-threatening self-harm within last six months
 - aged 18-65
- Exclusion criteria - kept to a minimum:
 - in a long term psychotherapeutic treatment
 - met DSM-IV criteria for psychotic disorder or bipolar I disorder
 - had opiate dependence requiring specialist treatment
 - had mental impairment or evidence of organic brain disorder
- NOT excluded: Current psychiatric in-patient treatment, temporary residence, drug and alcohol misuse, and other PD diagnoses



Design of intensive out-patient MBT randomized controlled trial.

- NHS referrals for IOP-MBT and SCM groups
- Random allocation (minimisation for age, gender, antisocial PD)
- Individual (50 mins) + Group (1.5 hrs) weekly for 18 months
- Assessments at admission, 6 months, 12 months, 18 months
- Medication followed protocol



Therapist recruitment

- 11 therapists were co-opted or recruited for the trial (MBT-OP=6, SCM-OP=5) **randomly assigned** to a 3 day training in MBT-OP or SCM-OP
- All therapists
 - minimum of 2 years' experience of treating patients in general psychiatric services following their generic training
 - minimum of 1 year's experience treating patients with personality disorder
- Therapists offering MBT-OP and SCM-OP did not differ in their years of psychiatric experience (mean [SD]: MBT-OP, 6.16 [1.6]; SCM-OP, 6.8 [2.3] years)



Therapist profession and training

- 7 nurses (MBT-OP = 4, SCM-OP = 3)
- 3 trainee psychiatrists (MBT-OP = 2, SCM-OP = 1)
- 1 accredited counselor (MBT-OP = 0, SCM-OP = 1).
- MBT-OP therapists completed a 3-day basic and a 2-day advanced training course in MBT. Supervision was offered on a weekly basis for 1 hour to all therapists as a peer group
- SCM-OP therapists attended 3 days of training on personality disorder discussing the nature of personality disorder, the common problems encountered in treatment and a focus on the SCM-OP protocol. Supervision was offered on a weekly basis for 1 hour by a senior clinician experienced in the general management of BPD.



Therapist Stance - MBT

- C – curiosity
- H – hope and optimistic attitude
- A – authenticity and affect focus
- T – transference mentalizing



Key Clinical Features

- Structure
- Focus on optimal stimulation of attachment system
- Careful ‘marking’ of experience
- Specific focus on mental processes
- Interventions must match mentalizing capacities of patient and not therapist



Contrary Moves

Patient/Therapist	Therapist/Patient
Knowing	Unknowing
Self- reflection	Other reflection
Emotional distance	Emotional closeness
Certainty	Doubt



Therapy

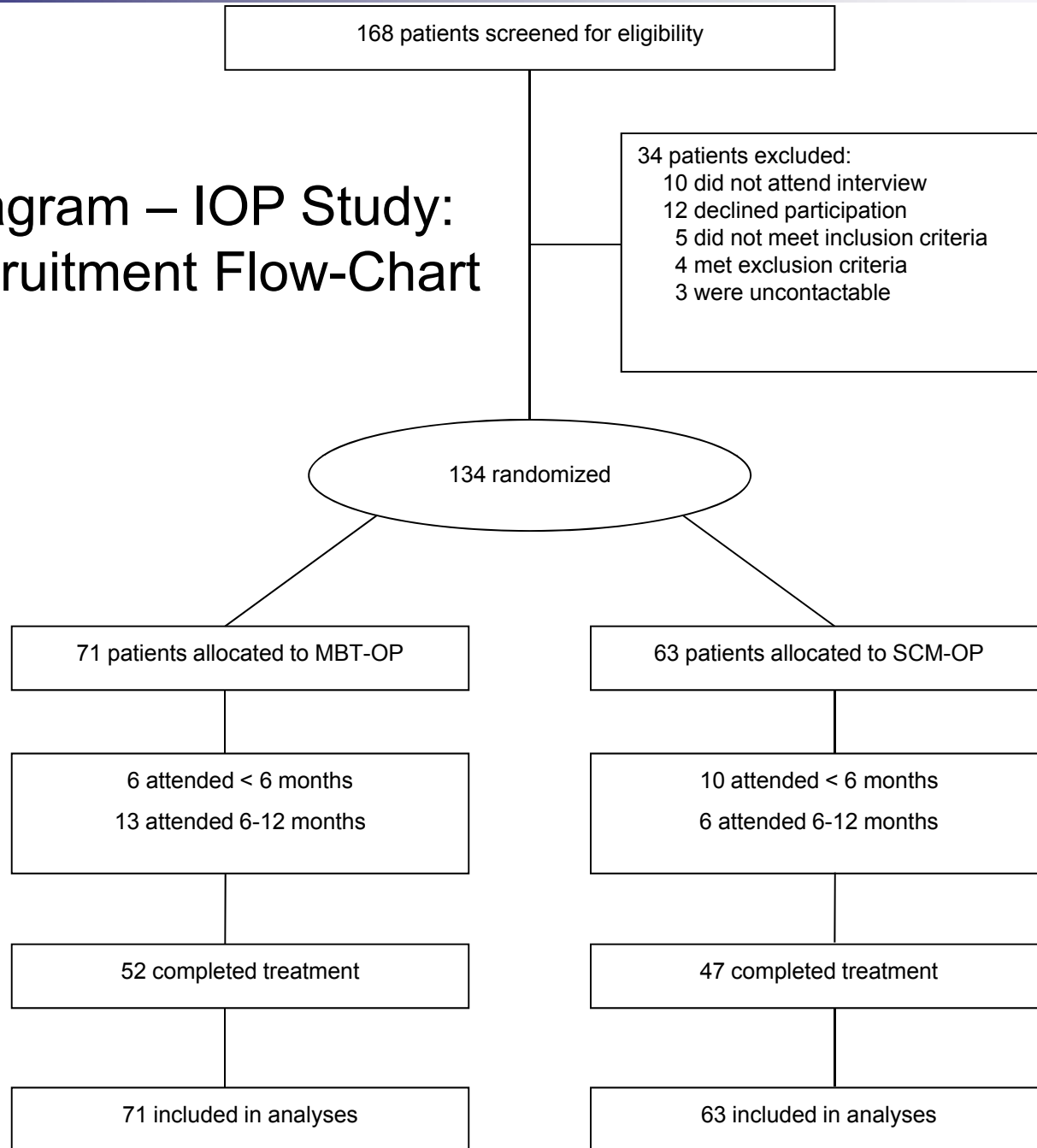
■ MBT - weekly

- Support and structure
- Challenge
- Basic mentalizing
- Interpretive mentalizing
- Mentalizing the transference
- Medication review
- Crisis management

■ SCM - weekly

- Support and structure
- Challenge
- Advocacy
- Social support work
- Problem solving
- Medication review
- Crisis management

Consort Diagram – IOP Study: Patient Recruitment Flow-Chart



Demographics

Variable	Exptl=71		Control = 63	
Mean age	31.3	<i>SD7.6</i>	30.9	<i>SD7.9</i>
Female gender	57	80.3%	50	79.4%
Married	14	20%	6	10%
Living alone	30	42.3%	31	50.0%
Children	9	21.0%	18	36.0%
Tertiary education	26	36.6%	27	42.9%
Current employment	20	28.2%	19	30.2%
State benefit	47	66.2%	43	68.3%

Demographics

Number	Exptl N=71		Control n=63	
White British/European	54	76.1%	43	68.3%
Black African/ Afro-Caribbean	11	15.5%	13	20.6%
Other Chinese/Turkish/Pakistani/	6	8.5%	7	11.1%
Early loss	36	50.7%	29	46.0%
Rape*	24	33.8%	11	17.5%
Sexual abuse	37	52.1%	32	50.8%
Physical abuse	26	36.6%	26	41.3%
Assaultative behaviour	21	29.6%	23	36.5%

Clinical Characteristics

Number	Exptl N=71		Control n=63	
Suicide past 6 months	53	75.0%	42	67.0%
Number of serious self-harm episodes past 6 months	4.1	SD 4.9	3.8	SD 3.7
Days of hospitalization past 6 months	5.5	SD 11.6	6	SD 12.4
Hospitalized past 6 months	23	32.0%	19	30.0%
Major depressive disorder	41	57.7%	34	54.0%
Depressive disorders -inc dysthymia	56	78.9%	47	74.6%
Posttraumatic stress disorder	9	12.7%	10	15.9%
Number of Axis 1 diagnoses	2.8	SD 1.3	2.8	SD 1.3
Drug misuse (>4x per week)	29	40.8%	26	41.3%

Clinical Characteristics

Number	Exptl N=71		Control n=63	
Cluster A	29	41.0%	27	42.9%
Cluster B other than BPD	40	56.0%	29	46.0%
Cluster C	30	42.3%	21	33.0%
Antisocial	21	29.6%	16	25.4%
Histrionic	11	16.0%	8	13.0%
Narcissistic	15	21.0%	10	16.0%
Paranoid	27	30.0%	24	38.1%
Schizoid	2	2.8%	4	3.6%
Avoidant	17	23.9%	11	17.5%
Dependent	18	25.4%	12	19.0%
Obsessive compulsive	2	2.8%	2	3.2%
No of Axis II diagnoses	2.4	SD1.1	2.3	SD1.0



Outcomes

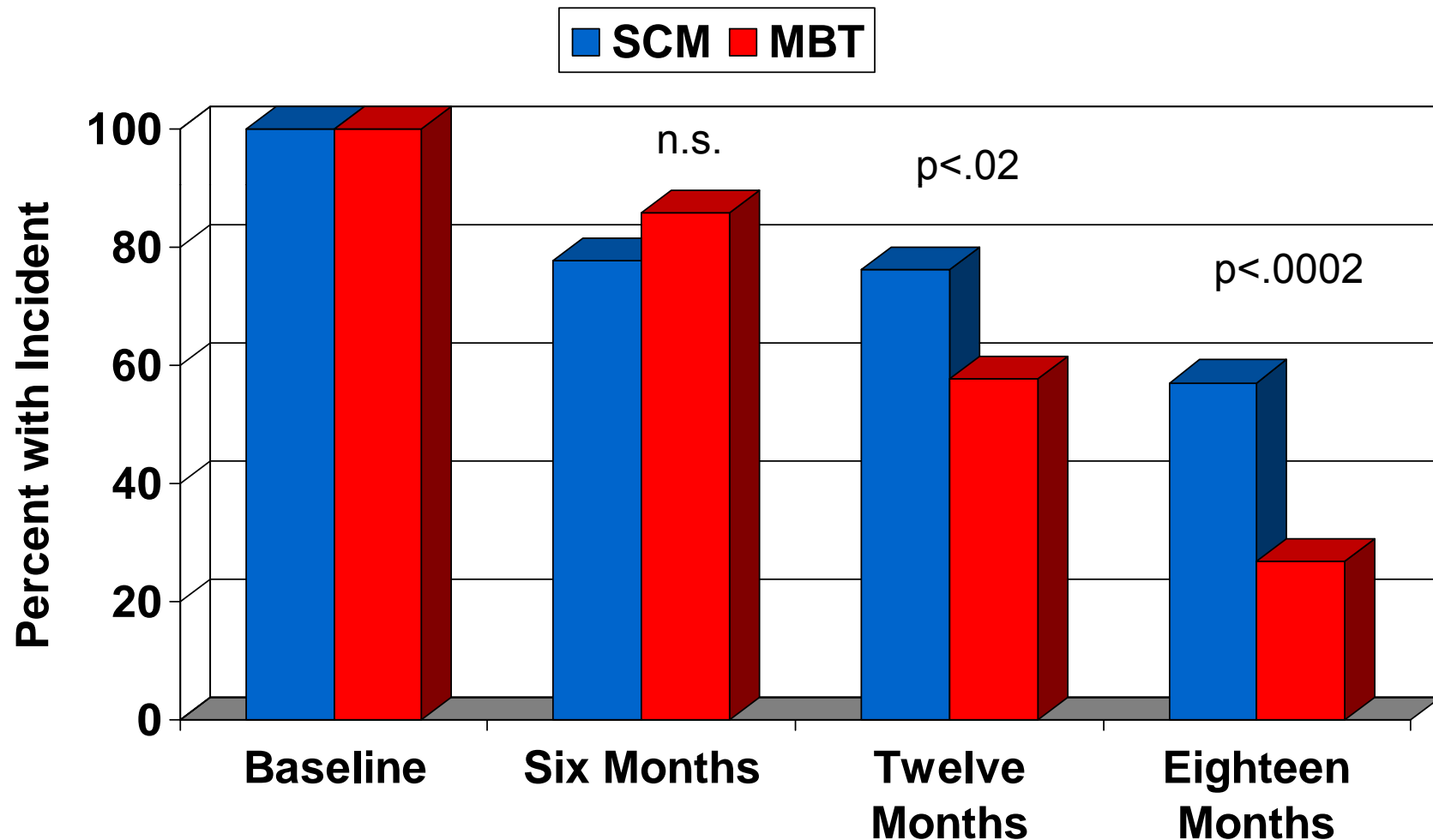
- **Primary outcome**

- proportion of each group without severe parasuicidal behavior as indicated by a) suicide attempt; b) life-threatening self-harm; and c) hospital admission

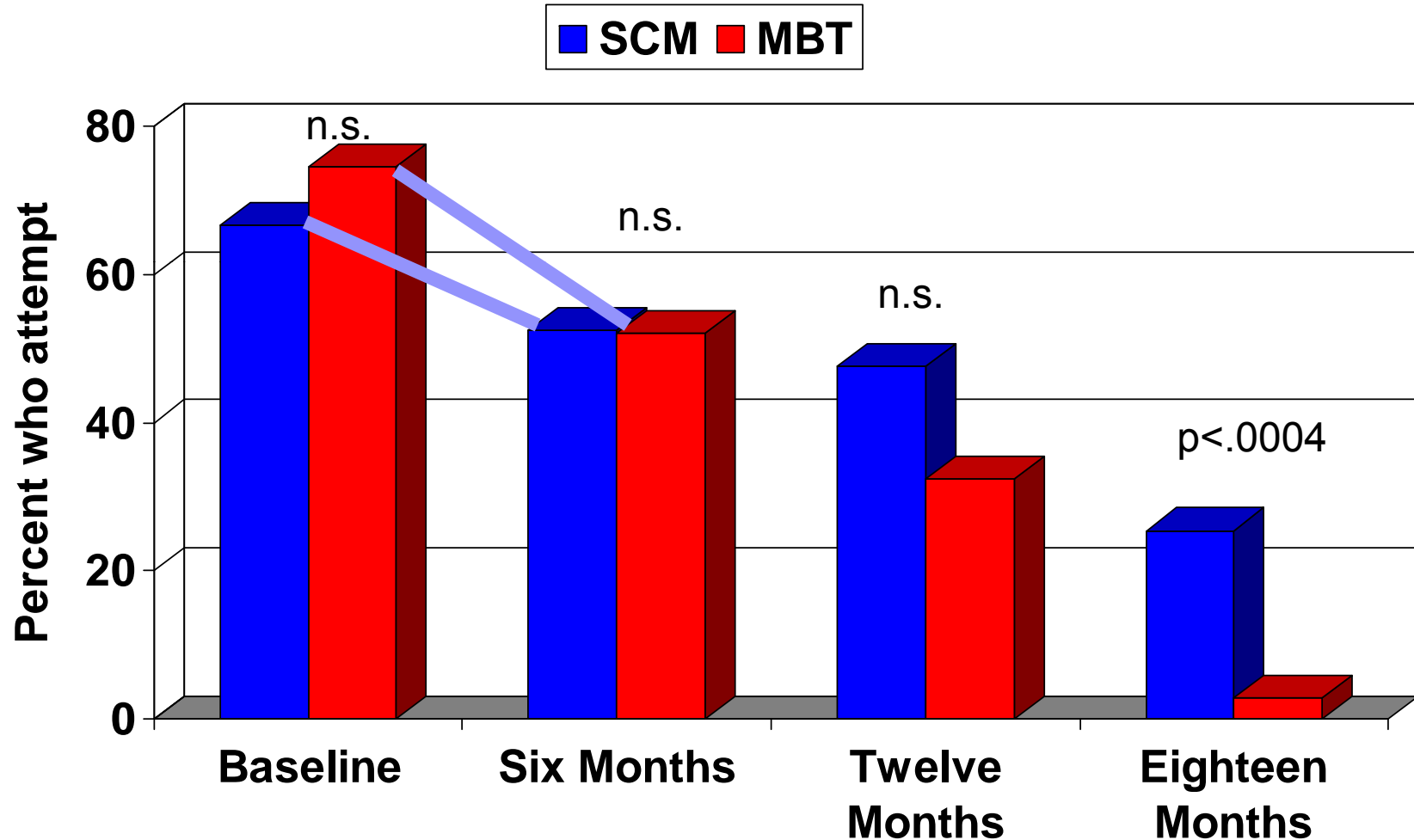
- **Secondary outcomes (assessed at baseline, and at 6-monthly intervals until the end of treatment at 18 months)**

- independently rated Global Assessment of Functioning (GAF) scores at beginning and end of treatments
- self-reported psychiatric symptoms and social and interpersonal function
- medication use assessed at baseline, and at 6-monthly intervals until the end of treatment at 18 months.

Percent of Sample Who Had Attempted Suicide, Self-harmed, or were Hospitalized in Last Six Months

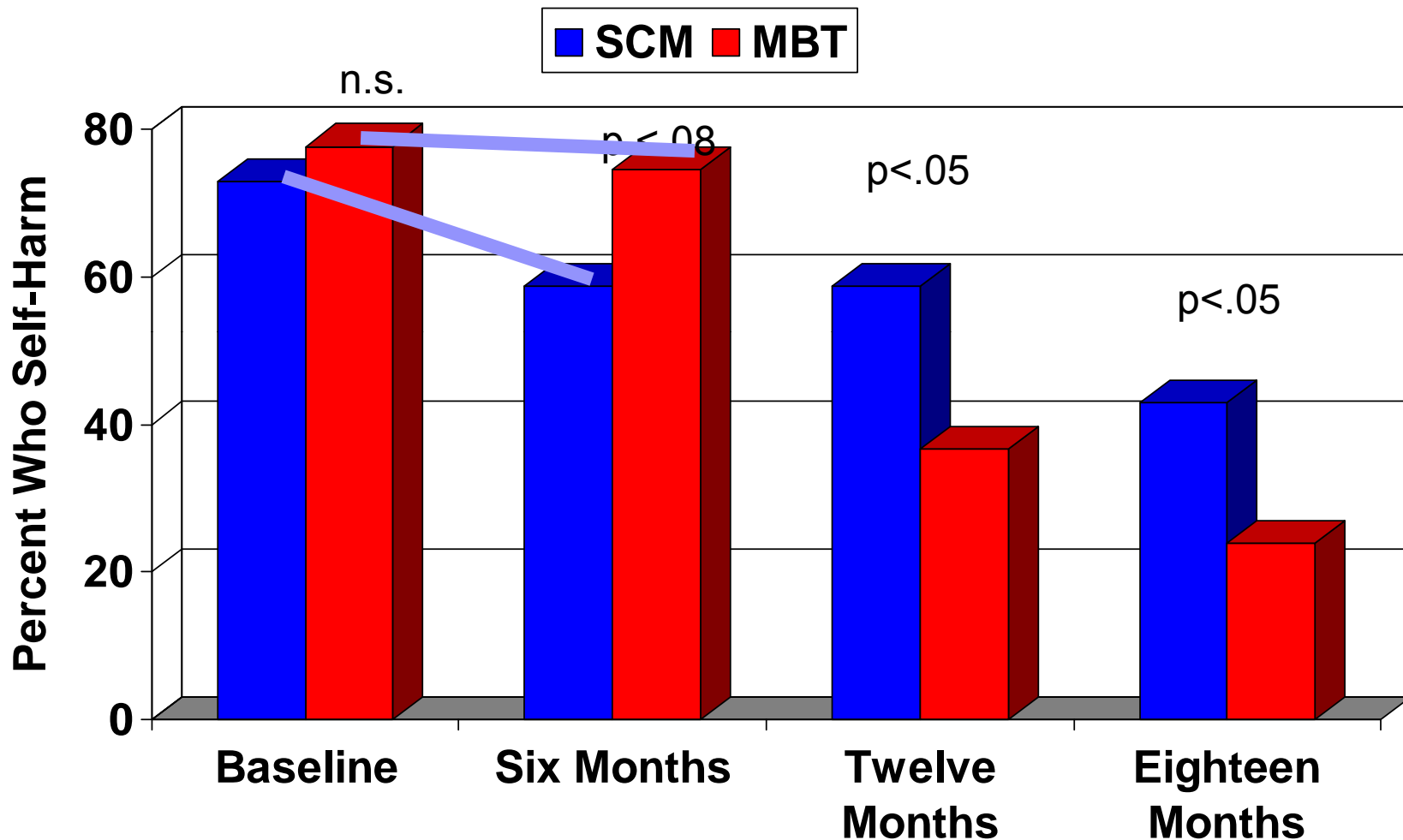


Percent who had made life threatening suicide attempt



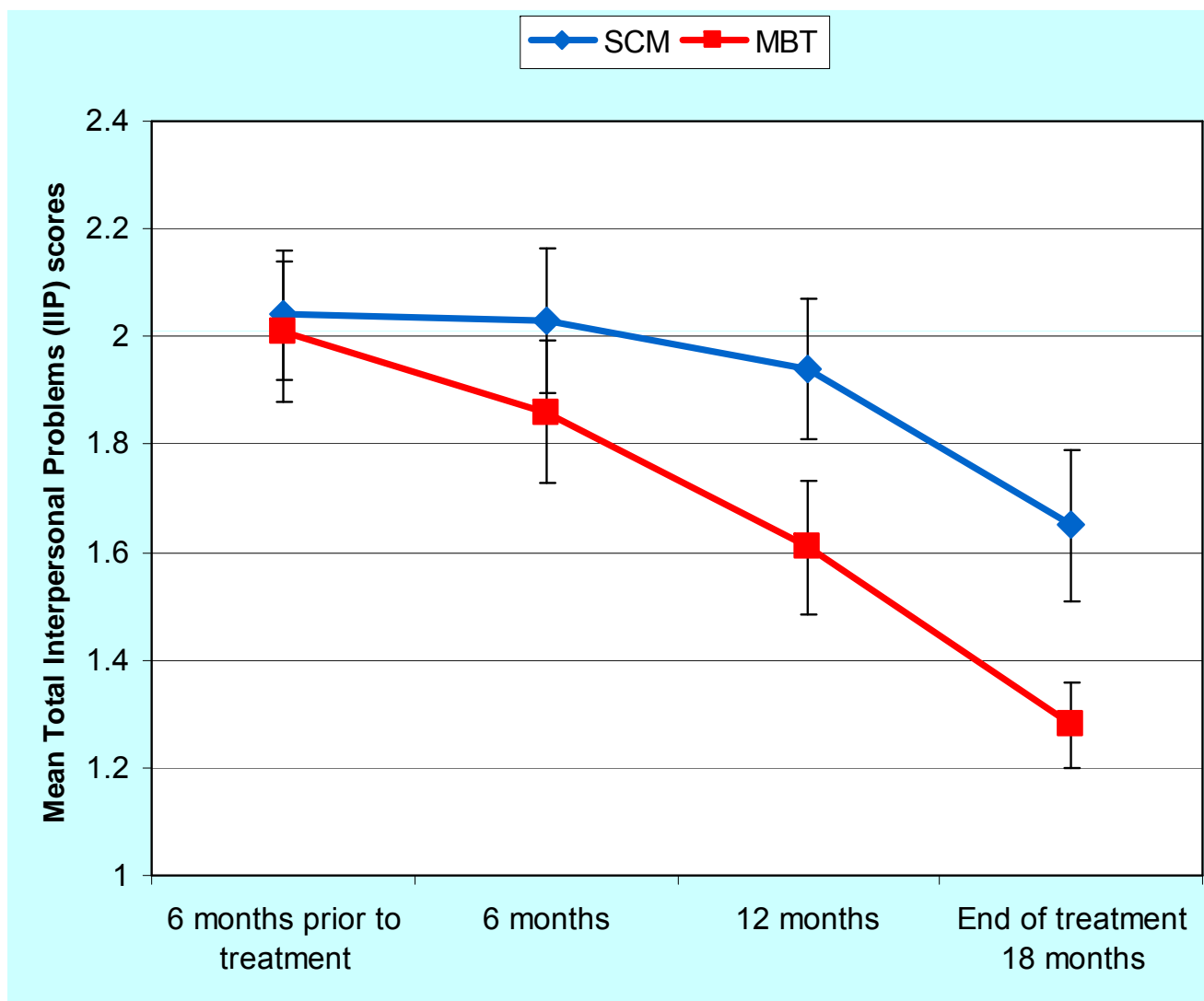
OR for combined group: 0.41 (.30, .57), Coefficient for group difference: 0.37 (.21, .62)
(At 18 months $\chi^2 = 12.8$, $p < .0004$, $RR = 0.11$, 95% CI: 0.02, 0.46)

Percent of who seriously self harmed



OR for combined group: 0.49 (.35, .69) , Coefficient for group difference: 0.39 (.23, .66)
(At 18 months $\chi^2 = 4.6$, $p < .05$, RR=0.55, 95% CI: 0.33, 0.92)

Average Interpersonal Problems Scores



Coefficient of difference between slopes=-0.12 (-.19, -.04), $p < .007$



Conclusions

- Both groups showed improvement over 18 months **BUT DIFFERENT RATES OF CHANGE**
- Structured, integrated and focused psychological and psychiatric treatment results in significant benefits for patients with BPD
- Rate of improvement in both groups was higher than spontaneous remission of symptoms of BPD estimated from follow-along studies
- Results support emphasis on structured treatment approaches (recently recommended in NICE guidance)




Conclusions

- MBT-OP was superior to SCM-OP – differences started to emerge after 6 months
 - suicide attempts and severe incidents of self harm
 - self-reported measures of psychiatric symptoms and social adjustment
- Specific psychotherapy addressing particular psychological functions assumed to be relevant to the symptoms of BPD gives additional benefits to a structured and integrated treatment program providing more generic psychological support.
- But we still do not know the mechanism of change



Conclusions

- Reasonable outcomes may be achievable within the framework of regular mental health service provision without need for lengthy specialist training
- Supports the general utility of MBT
- Contraindicates adoption of non-focused generic approaches and/or premature exclusive adaptation of any one therapeutic model.



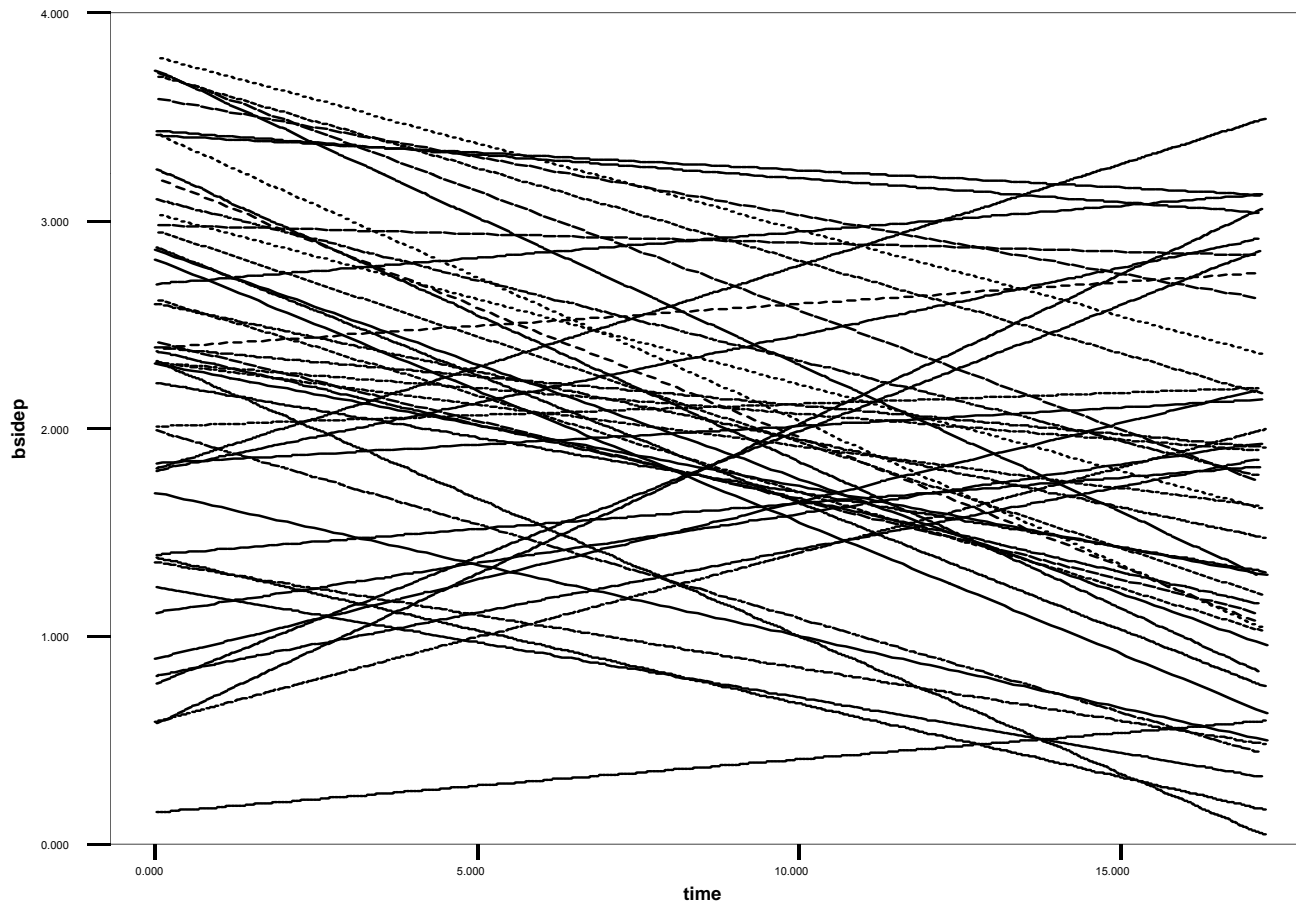
*The results of the intensive
outpatient treatment trial of MBT
for BPD patients: what has it
made us think about?*



Hierarchical Linear Modelling

- Multilevel modelling applied to the data
- Flexible in treatment of time as a continuous factor
- Allows for variability in actual time of assessment for each participant
- Look at the trajectory of individuals
- Who gets better?

Individual Growth Curves: Depression over Time



Linear Regression



Gaps in Outcomes Research

- No solid evidence for who will benefit from what type of psychotherapy
- ‘Inexact therapies’ → partial effectiveness
- ‘Attachment to methods’ → ‘guildification’ of interventions




*The Impact of Therapists and
Therapeutic Alliance on
Treatment Outcome*



Reducing the Harmful Effects of Psychotherapy: The work of Lambert (2009)

- Across studies the rate of observed deterioration in psychotherapy was 10-25% with young people
- Some therapists have rates of deterioration of around 50% and their treatment is NEVER associated with recovery
- Introduction of *outcome tracking* (session by session monitoring)
 - Early warning when patient goes off trajectory
- Therapists randomized to feedback vs no-feedback
 - Deterioration reduced by 50%
 - Recovery improves by 50%
 - Average therapy is shorter
 - Patients who show early negative response receive longer and more effective treatment



Do no harm... outcomes informed care

- Most therapists see themselves as better than average:

Dew & Riemer (2003, 16th Annual Research Conference, University of South Florida)

- 143 counselors asked to grade their job performance on scale from A+ to F
 - 66% rate themselves as A or better
 - none rated themselves as below average

- Outcomes informed care may be a critical way of linking the EBP approach and practice based evidence



Is Therapeutic Alliance a Mediator of Change?

- Therapeutic alliance may be a mediator and mechanism of therapeutic change
 - The stronger the alliance the greater the change (eg Horvath & Bedi 2002; Orlinsky et al 2004)
 - Correlational studies show alliance predicts improvement in symptoms at end of treatment
 - Is it the good relationship with the therapist that cures?



Therapeutic alliance in SFT and TFP

Spinhoven, P et al (2007) J Consult Clin Psychol 75 104-115

- Scores of patients and therapists on therapeutic alliance were higher in SFT than TFP
- Negative ratings early in treatment were predictive of drop out which was higher in TFP
- Increasing ratings in 1st half of treatment predicted clinical improvement

BUT

- This does not appear to be universally the case and does not imply causality

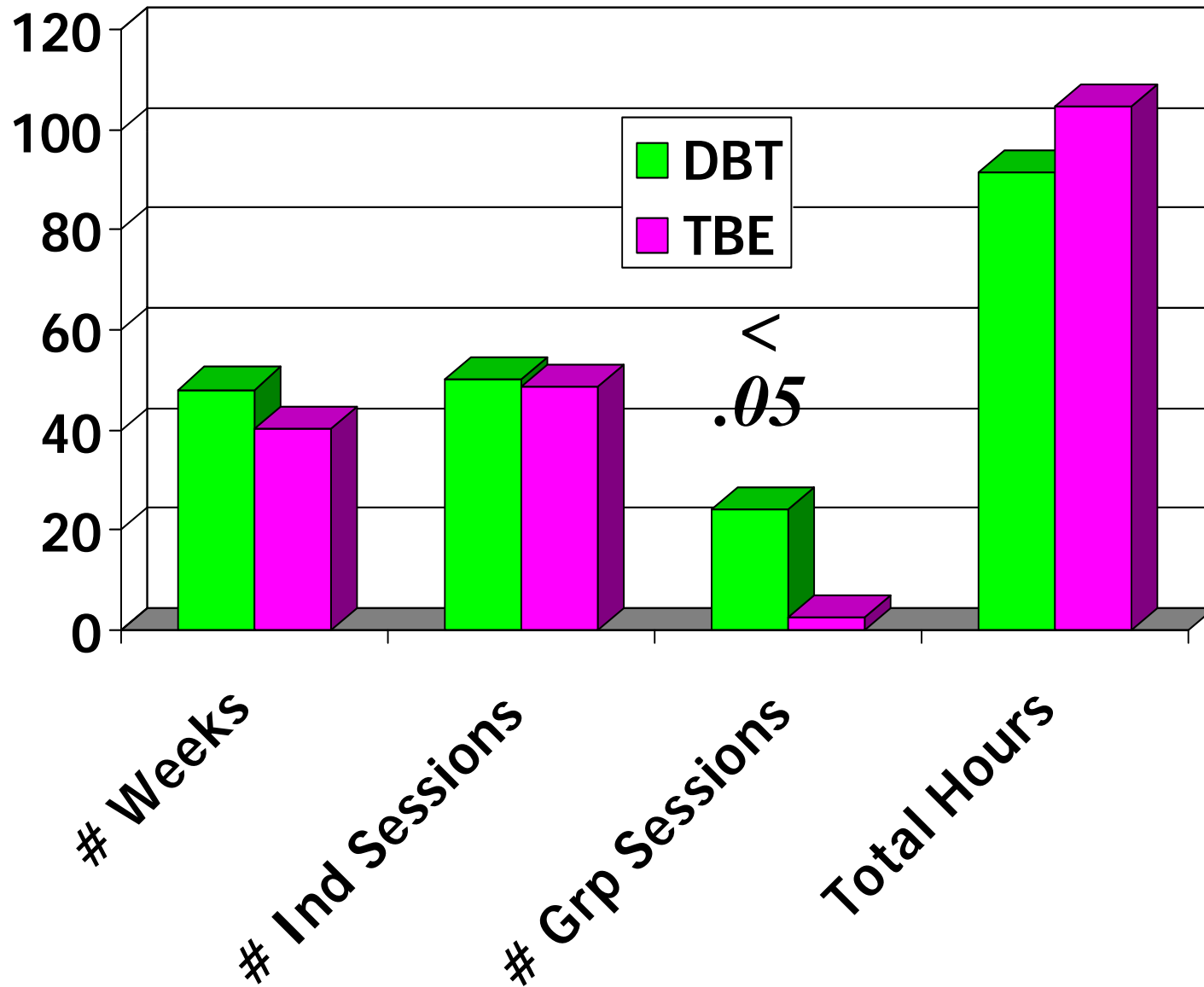


Therapeutic Relationship DBT 'v' CTBE

Linehan, M et al (2006) Two-year randomized controlled trial and follow-up of dialectical behavior therapy vs therapy by experts for suicidal behaviors and borderline personality disorder. Archives of General Psychiatry 63, 757-766

- Therapeutic relationships and trajectory of treatment likely to differ
 - CTBE highly eclectic (humanistic/dynamic/supportive)
 - No group supervision or group treatment in CTBE
 - Structured uniform DBT (e.g. acceptance vs change) response vs unstructured/variable responses
 - More unstructured treatment in CTBE – inpatient, day patient
 - Development of crisis interventions variable

DBT vs CTBE: Amount of Therapy






Therapist Technique

Davidson K, et al (2007) Integrative complexity analysis of cognitive behaviour therapy sessions for borderline personality disorder. *Psychology and Psychotherapy: Theory, Research and Practice* 80 513-523

- Therapists may overcompensate for patient's poor outcome by giving more complex explanations to patients. Higher complexity does not necessarily lead to better outcomes
- Therapists who give over-complex explanations engage in developing a poorer outcome by not matching intervention to mentalizing capacity and so inducing harm




*The Activation of the
Attachment System and
Mentalizing in Psychotherapy*



The nature of BPD therapies

- Many individuals with BPD ‘recover’ to a significant extent without extensive formal therapeutic intervention
- Many therapies are highly effective for BPD
- Many therapies appear to do harm to individuals with BPD or at least appear to be able to impede a natural process of recovery
- The Fonagy & Bateman Principle:
 - *A therapeutic treatment will be effective to the extent that it is able to enhance the patient’s mentalising capacities without generating too many iatrogenic effects.*
 - *Iatrogenic effects are reduced if intensity is carefully titrated to patient capacities and if treatment is coherent and flexible.*



Implications for therapy and the mechanisms of change

- Psychotherapy in a range of contexts attempts to **enhance mentalisation** in part by generating the context of an **attachment relationship**
 - the discussion of **current and past** attachment relationships → intensifying internal working models of attachment relationships
 - assisting with the patient's regulation of affect
 - through **contingent marked** responding to the patient's affect
 - creating a **safe and sensitive** interpersonal environment
 - creating alternative perspectives on mental experience
 - interpreting the transference
 - recovering from ruptures of the therapeutic alliance




*The Transference, the Hyperarousal
of the Attachment System and
Mentalizing*



Attachment Disorganisation in Maltreatment

Adverse Emotional Experience

The 'hyperactivation' of the attachment system

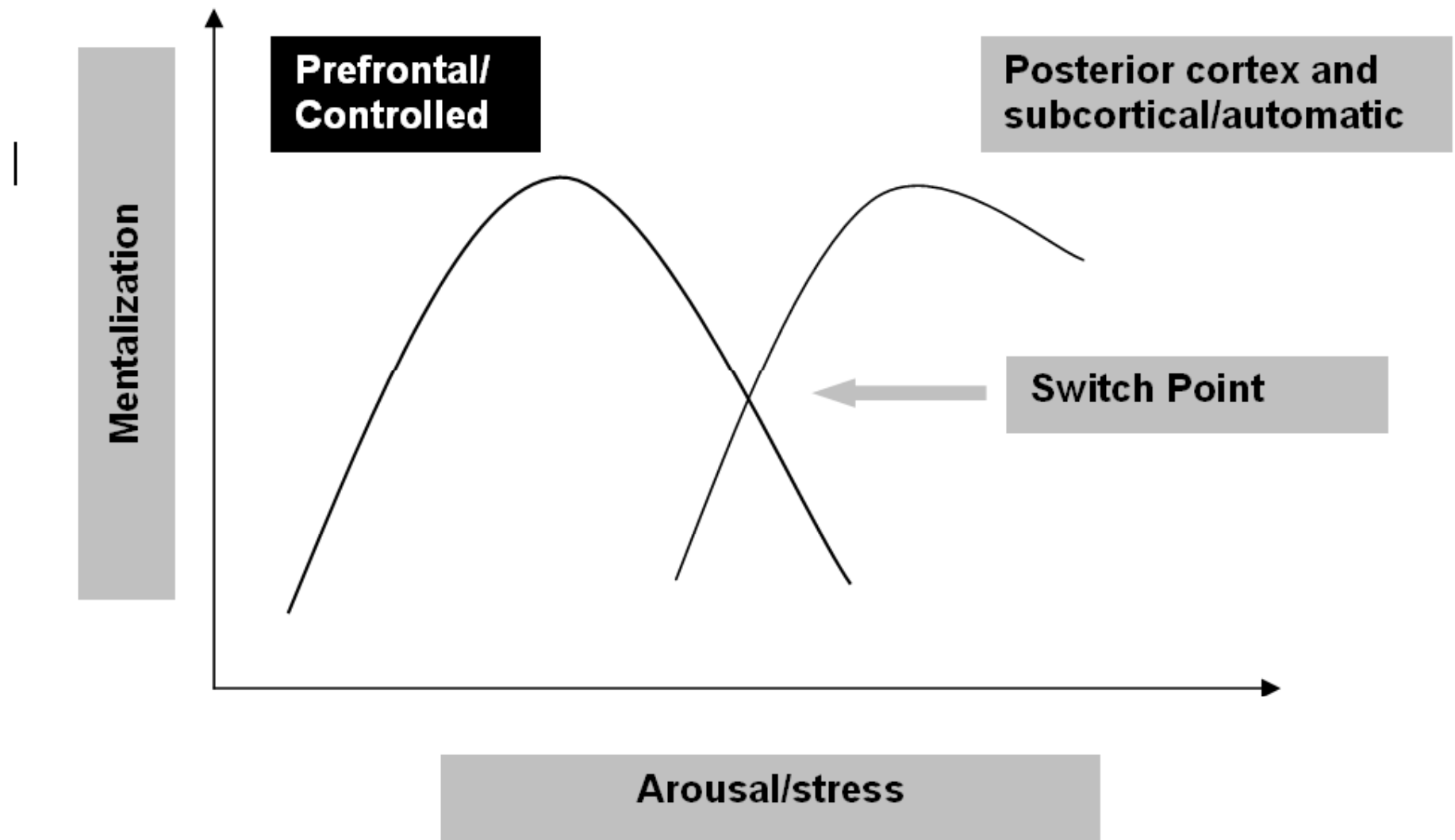


Attachment Disorganisation in Psychotherapy

Emotionally Challenging
Experiences in Relation to the
Therapist

The psychotherapeutic 'hyperactivation' of
the attachment system

A biobehavioral switch model of the relationship between stress and controlled versus automatic mentalization (Based on Luyten et al., 2009)





Implication for psychotherapy

- Intensification of attachment relationship with therapist activates attachment system and strengthens mentalization when carefully managed
- Therapist has to retain capacity for marked mirroring
 - As secure mother must markedly mirror sadness rather than feel it (or feel overwhelmed by it)
 - Experienced therapists show less affect on face when with patient than inexperienced ones
 - Must be able to stop short of hyperarousal and must avoid intensifying attachment relationship to the point that
- Over-activation of attachment relationship comes to undermine mentalizing capacity in the patient
 - Must be aware of moment to moment changes in patient's mental state
 - Interpretations or complex interventions are often given when patient is least able to adopt an intentional stance



Provision of management and structure from MBT perspective - early

- Authenticity, affiliation, openness, warmth early
- Do not give excess autonomy to patient early in treatment – joint responsibility
- Clarity of roles and focus
- Disengage the attachment system in face of actions e.g. self harm. More=Less (no admission);
- Re-engage attachment system in therapy relationship
- Primary technique – see experience from patient perspective
- Monitor trajectory of treatment
- Crisis plan development ? Process of development and reaction to activated plan more important than actual plan
- Instructional attitude initially



Provision of management and structure from MBT perspective - late

- Authenticity, affiliation, openness, warmth
- Increasing autonomy to patient
- Clarity of roles and focus
- Disengage the attachment system in face of actions e.g. self harm. More=Less;
- Re-engage attachment system more intensely in therapy relationship
- Primary technique – see experience from patient perspective but develop alternative perspectives
- Patient responsible for crisis plan development and activation of non-therapy interpersonal solutions



Conclusions

- Structure and organisation
- Autonomy and choice
 - Healthcare professionals should work in partnership with people with borderline personality disorder to develop their autonomy and encourage choice by:
 - ensuring they remain actively involved in finding solutions to their problems, even during crises
 - encouraging them to consider the different treatment options and life choices available to them, and the consequences of the choices they make
 - Develop functional crisis intervention



Development of joint crisis plan – RCT in progress (Moran et al)

- Developed with patient, mental health professionals involved, family, supporters, partners
- Held by patient and services
- Identifies patient preferences and professionals preferences
- Maintains people in services and prevents drop-out



Conclusions

- Will it be adequate to effect lasting change?
- Perhaps this will depend on how professionals interact when the plan is activated
- Do they need training in mentalizing?
- Future research needs to compare training of mental health professionals
 - how to develop crisis plans
 - how interact with people with BPD rather than training them in our 'guildified' models
 - then assess outcomes within generic services



Thank you for
mentalizing!

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<http://www.ucl.ac.uk/psychoanalysis/unit-staff/staff.htm>