Psychotherapy for Borderline Personality Disorder

mentalization-based treatment

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The prevailing views about the treatability and treatments for patients with borderline personality disorder have changed dramatically during the course of the thirty years in which this diagnosis has been used. Long-term individual psychoanalytic psychotherapy was considered the treatment of choice in the 1970s. The basis for this view was laid by the claims made for its effectiveness in a series of more than 50 books authored by psychoanalytic pioneers, who described the techniques, processes, and problems involved in conducting such therapies. After the diagnosis entered the official nomenclature of the American Psychiatric Association (APA) in 1980, its treatment received increasing attention from psychiatrists. During the decade of the eighties the rarity of success with psychoanalytic therapists and the potentially harmful effects of long-term or unstructured hospitalizations became widely recognized. In the same decade medication trials were begun, that, despite ambiguous results, established this modality as a standard of treatment for borderline patients. In the 1990s the social disabilities of borderline patients became central to therapeutics, and empirical evidence became a new standard for judging effectiveness. Family and group therapies both received support in preliminary trials. Without question, however, the major advance in the 1990s was the emergence of a behavioural therapy, DBT, directed at the self-destructive behaviour of these patients. Championed by empirical support and the tireless and charismatic advocacy of Marsha Linehan, DBT threatened to eclipse claims of benefit from all other therapies. It is in this context that the contribution of what in this book is called “Mentalization Based Therapy” (MBT) by Bateman and Fonagy appeared.

MBT has been shown to be effective in a randomized controlled clinical trial (Bateman and Fonagy, 1999). In that study, MBT was provided in a partial hospital setting for 18 months and was contrasted with usual psychiatric care. Like DBT, MBT showed dramatically effective results in diminishing hospitalizations, medication usage, and suicidal and self-injurious behaviours. In addition, and unlike DBT, it also showed significant benefits in symptoms of depression and anxiety, and in social and interpersonal function. Particularly impressive was that patients continued to improve during an 18-month period of follow-up (Bateman and Fonagy, 2001). In *Psychotherapy for borderline personality disorder*, the developers of this treatment provide a manual that will allow clinicians to understand and deploy it.

MBT is derived from a developmental theory advanced by Fonagy nearly a decade ago (Fonagy, 1991; Fonagy and Target 1997). This theory is based on systematic observations of infants with their caretakers, and is anchored within
the growing science on attachment. It posits that a sense of self develops from observing oneself being perceived by others as thinking or feeling. The stability and coherence of a child’s sense of self depends upon sensitive, accurate, and consistent responses to him and observations about him by his caretakers. By internalizing perceptions made by others about himself, the infant learns that his mind doesn’t mirror the world, his mind interprets the world. This is termed a capacity to “mentalize”, meaning the capacity to know that one has an agentive mind and to recognize the presence and importance of mental states in others. As applied to BPD, the authors assert that failures of parental responsiveness cause a failure in ability to mentalize, and thus an unstable and incoherent sense of self. The inability to mentalize and the consequent incoherence of self are reflected in the Borderline patient’s typically inconsistent and often inaccurate perceptions of self and others, and in their inconsistent and inappropriate expressions of emotions. It is worth highlighting that the borderline patient’s emotional volatility that is thought to be the core deficit (i.e. “emotional dysregulation”) in borderline patients by Linehan, Livesley, and other major theorists, is in Bateman and Fonagy’s theory reduced to a secondary phenomenon.

By promoting a theory in which the core deficit of BPD is an environmentally, and specifically parent-child, induced failure to develop a psychological function (i.e. mentalization), the authors are giving priority to once prominent etiologic factors that have faded in the face of growing evidence for biogenetic vulnerabilities, such as affective instability or behavioural dyscontrol (i.e. impulsivity). Prioritizing the environment and the interpersonal domain in interaction with genetic vulnerability offers a valuable and timely counterpoint to theories that propose biogenetic dispositions as the core of this disorder. At this point in our knowledge, contrasting theories are desirable stimuli to testable hypotheses and better understanding of borderline personality disorder. In this regard, Bateman and Fonagy are wonderfully forthright by repeatedly identifying differences between theory and knowledge, and when explicating their theory ask readers only to respect its plausibility. Such distinctions and modesty are usually absent when authors have a theoretical conviction.

As a manual, much of this book describes practical applications for the authors’ developmental model of borderline psychopathology. The core and distinguishing characteristics of the MBT interventions are the attention given to identifying the mental state of others as the way to understand behaviour. Thus therapists focus on identifying (interpreting) here-and-now feeling states or thoughts in their BPD patients. Unlike usual psychoanalytic interventions, with MBT it is not the content of an interpretation that is thought to bring about change. Rather, change derives from the more generic lesson about the causal role of mental states in explaining or understanding behaviour. Moreover, in MBT, another focus is on having patients identify mental states in others, including that of the therapist, and to learn how they explain behaviour by others.
The emphasis on cognitive processes in the here-and-now is the level of therapist participation that bridges traditional cognitive and psychoanalytic techniques.

The application of MBT that has been empirically validated by Bateman and Fonagy took place in a partial hospital program, but the authors are clear that they believe it is the individual therapy and group therapy components that account for MBT’s efficiency. This belief is now being tested, but their effort to sort out the effective components illustrates this book’s larger purpose: MBT is a theory-based model of therapy whose possible applications are intended to be diverse — and certainly not confined to extended partial hospital services. This message is critically important and I expect that readers will find, as I have, that the attention to mental states given within MBT is a useful framework for thinking about what one is doing in all encounters with borderline patients. The attention and importance given to recognizing and labelling what a patient is thinking and feeling is an essential form of validation and self-building that cuts across all therapeutic modalities or paradigms.

This is a significant book written by two serious clinician-scientists. Beyond introducing readers to MBT and its theoretical background, the book contains multiple cogent and scholarly reviews of relevant BPD literature. The authors are not trying to simplify; they want readers to receive an education in a way of thinking about borderline patients that will modify currently prevailing conceptualizations and usual practices. It should become essential reading for all serious scholars and clinicians of borderline personality disorder.

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The term personality remains one of the most confused and abstract ideas within psychiatry and psychology and there are frequent attempts to discard the concept altogether. Yet each generation of academics and practitioners seem to have to rediscover its significance in clinical practice (Livesley 2001) and over the last decade there has been increasing interest in the notion of personality disorder both in its own right (Rutter 1987; Clarkin and Lenzenweger 1996) and as a problem that interferes with treatment of other mental health problems. The result has been the development of multifaceted treatments which have led to a guarded optimism (Higgitt and Fonagy 1992b; Pilkonis et al. 1997) that personality is changeable and treatable. This manual has been developed within this positive climate. Yet, despite the present zeitgeist, considerable problems remain in writing a manual for the treatment of borderline personality disorder. The aim of a manual is to help practitioners organize their thinking about a specific group of patients and to advise them what they need to do to treat them effectively. But even in short-term treatments lasting 12–16 sessions, no manual can cover all the clinical events that may occur during treatment. This is all the more so with this manual which is about a long-term treatment for patients with personality disorder. Manuals addressing long-term treatment are rare and cannot provide adequate detail about every clinical situation. This manual is no exception and you, the practitioner, will have to use discretion and ingenuity.

Aims

The overall aims of this manual are to:

• orientate the reader to our approach;
• ensure that the practitioner knows how to organize the programme;
• outline appropriate use of the strategies, tactics, and techniques;
• stimulate thinking about how to develop creative strategies consistent with the model in the many clinical situations that will arise.

It is important for a number of reasons that the manual is not followed slavishly. First, such an approach is likely to distort the interaction between the