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COGNITIVE –BEHAVIORAL THERAPY IN BORDERLINE PERSONALITY DISORDER (BPD) TREATMENT

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Summary

A Borderline personality disorder is a serious, chronic mental health problem with a severe course, associated with multiple negative consequences. Its prevalence in the general population is estimated between 1.6 and 5.9%, and multiplies among psychiatric patients. This disorder is characterized by a disturbed, unstable image of oneself, one's goals and preferences, impaired impulse control, emotional deregulation, repeated self-injury, chronic suicidal tendencies and recurrent difficulties with interpersonal relationships. Given these characteristics, implementing effective therapeutic interventions is a challenge for clinicians. Until recently, there seemed to be a widespread view that there were no effective therapy that could ensure long-term improvement of the psychological functioning of patients with this diagnosis. Research conducted over the past three decades has provided new theoretical concepts, laying the foundation for therapeutic interventions of empirically proven effectiveness. The aim of this paper is to present the role that cognitive-behavioral therapy plays in the treatment of borderline personality disorder. It briefly presents three conceptualizations of borderline personality and reviews the current literature on the effectiveness of therapeutic protocols based on these theoretical models.

Introduction

Borderline personality disorder (BPD) is a significant mental health problem with a chronic, severe course, associated with harmful, multidimensional consequences at the individual, systemic, social, economic and medical levels [1]. Its prevalence in the general population is estimated between 1.6 and 5.9% [2], while considering the frequency of occurrence in the group of psychiatric patients it increases to 20% among outpatients [3] and even 40% of inpatients [4]. The diagnosis of BPD is three times more frequent in females [5]. The widely described emotional deregulation, manifested by increased reactivity to emotionally charged stimuli, greater intensity and longer reaction extinction time, is the basis of the current diagnostic criteria [6]. The clinical picture is completed by

impulse control disorders, instability and uncertainty of the self-image, one's own goals and inner preferences, and chronic feelings of emptiness [7]. The discussed difficulties lead to repeated dysfunctions in interpersonal relationships and significantly increase the risk of self-destructive behaviors, including parasuicidal gestures and suicide attempts [8].

The co-occurrence of "borderline" personality disorders with other psychiatric disorders, i.e. unipolar and bipolar affective disorders, eating disorders, and anxiety disorders, including primarily post-traumatic stress disorder, psychoactive substance dependence syndromes, psychotic disorders or other personality disorders, is a common phenomenon [9].

Considering the above characteristics, the introduction of effective therapeutic interventions in the treatment of BPD is a challenge for clinicians. For decades, clinicians believed that there were no effective methods of influence that could bring long-term improvement in the functioning of patients diagnosed with "borderline" personality [10].

Borderline personality disorder – current treatment guidelines

A systematic review of reports on pharmacological interventions in the treatment of borderline personality disorders, carried out by Hancock-Johnson, Griffiths and Picchioni, showed a persistent gap in the field of scientifically well-grounded evidence of the effectiveness of these methods [12]. The latest research in the field of pharmacotherapy in BPD has verified the effectiveness of second-generation antipsychotics, mood stabilizers, antidepressants and opioid receptor antagonists. They did not bring clear conclusions that could be the basis for formulating guidelines for discussing disorder treatment. Therefore, there is a need to extend the scope of evidence for pharmacotherapy based on extensive, randomized controlled trials, using the double-blind trial method. Psychotherapy is considered to be the basic method of BPD treatment [13]. The National Institute for Clinical Excellence guidelines for psychological interventions are formulated in a general manner. They indicate the need to use a coherent theoretical concept, to conduct therapeutic interactions for a period of not less than 3 months and to adjust the frequency of sessions to the individual characteristics of the patient. They also suggest the preferred choice of dialectic behavior therapy for women with a history of repeated self-destructive behaviors, including suicide attempts [14].

Currently, two therapeutic approaches, psychodynamic and cognitive-behavioral, which have a solid theoretical basis and developed work protocols that allow empirical verification of their effectiveness, are considered preferential [15]. There are two psychodynamic models consistent with the NICE recommendations for the treatment of borderline personality disorders. It is a mentalization-based therapy [16] and transference-focused therapy [17].

In the cognitive-behavioral paradigm, three conceptualizations of BPD are best grounded in scientific evidence: the dialectical behaviour therapy (DBT) [18], Young's model of early maladaptive schemas [19], and the classic cognitive therapy protocol [20].

Dialectical behaviour therapy (DBT)

Dialectical behaviour therapy is a therapeutic approach developed by Linehan since the late 1980s, which was created in response to the lack of a comprehensive, structured and effective strategy in the treatment of patients with borderline personality disorder, belonging to the group with high suicide risk [21]. Understanding the nature of borderline personality disorder is based on the biosocial model, which considers the dysfunction of the emotion regulation system to be the basic etiological factor. It manifests itself, among others, through an immediate and intensified response of the body to emotional stimulation and extended time of extinguishing the reaction. This deregulation is considered to be the result of interactions between biological factors and unfavorable environmental conditions in which an individual grows up. The nature of the difficulties experienced by patients with borderline personality disorder is therefore secondary to the discussed dysfunction in the processing of emotions [22]. Linehan considers the experience of emotions to be a comprehensive response of the body to stimuli, which consists of biochemical, cognitive, behavioral, phenomenological reactions and those related to motor and facial expression. The inability to control or modulate any area results in deregulation of the emotional processing system [21]. Self-aggressive behaviors, including suicide attempts, are therefore a form of ineffective emotion regulation [23]. Its consequence is also the inability to maintain stable interpersonal relationships, the tendency to impulsive behavior, including aggressive behavior, the presence of cognitive distortions (e.g. dichotomous thinking) [22].

The second postulate related to the pathogenesis of borderline personality disorder concerns the invalidating environment. They are characterized by a tendency to ignore, trivialize the expression of thoughts and emotions of the individual, not recognizing and not responding to basic emotional needs. With the passage of time, people growing up in a depreciating environment lose self-confidence, adopt a self-defeating attitude, display difficulties in recognizing their own emotional states, and thus lack the ability to regulate emotions. [24]. Considering the above postulates, in the treatment of people suffering from borderline personality disorder, the therapist is expected to adopt a dialectical attitude, the consequence of which is a systemic, holistic approach to the difficulties experienced by patients. The dialectical therapeutic process includes seemingly incompatible positions, such as acceptance and change, and then strives to balance and synthesize them [25].

The basic protocol of dialectical-behavioral therapy, with the most often verifiable effectiveness, consists of four inseparable elements:

- individual psychotherapy – including weekly, 60-minute sessions during which current difficulties are discussed, systematized in terms of priority in their elimination (1) self-destructive behaviors and suicidal tendencies, 2) behaviors that threaten therapy, 3) behaviors interfering with the quality of life)
- group skills training – including weekly 2.5-hour meetings

- telephone consultations – tailored to the individual needs of patients and the availability of therapists, in order to practice newly acquired personal skills.
- team consultations for therapists – in the form of weekly supervisions.

The above mentioned standards are to ensure conditions for the implementation of five basic areas of comprehensive treatment, i.e.:

- improving coping skills by training emotional regulation skills, increasing emotional distress tolerance when change is slow or unlikely, equipping crisis management techniques to replace self-destructive behaviors, developing interpersonal skills, including learning conflict resolution strategies, and learning mindfulness techniques to help you ground yourself in reality.
- increasing motivation to change maladaptive behavior patterns through the use of intensive behavioral analysis, exposure techniques and cognitive modification procedures.
- providing new opportunities to deal with the problem, i.e. telephone consultation.
- structuring the therapeutic environment to reinforce adaptive patterns of behavior.
- improving the competencies and maintaining the motivation of therapists through constant, regular group supervision[18].

The first randomized controlled trials on the effectiveness of dialectic-behavioral therapy showed its advantage over standard treatment methods (TAU: treatment-as-usual) for borderline personality disorder, which was reflected in a significant decrease in self-destructive behaviors, including suicidal behavior, shortening of hospitalization time and a decrease in the number of patients resigning from the therapeutic process [26]. The results supporting the higher effectiveness of dialectical behavioral therapy compared to TAU were confirmed in studies conducted by independent research teams on various patient populations [27, 28, 29]. It is worth noting that there is also evidence suggesting that the discussed effect is specific to dialectical-behavioral interactions in comparison to other active forms of psychotherapy conducted by trained specialists (i.e. client-centered approach or community therapy conducted by professionals) [18, 30 31].

Schema therapy

Schema therapy is an eclectic therapeutic approach derived from the cognitive-behavioral approach, combining elements of attachment theory, object relations, Gestalt and constructivism. It was created in response to failures in the treatment of patients suffering from profound personality disorders using standard techniques of cognitive-behavioral therapy [32]. It is assumed that the aetiology of borderline personality disorder is related to three types of factors. Firstly, it is associated with inborn temperamental predispositions, i.e. lability and emotional reactivity. The second factor is the environment in which the child grows up. The authors point to four specific features of the family

environment related to the genesis of BPD: 1) lack of security and stability, 2) deprivation of emotional needs, 3) excessive criticism and rejection, and 4) requirements of absolute submission. The last of the postulated factors is the mismatch between the needs of the child resulting from temperamental factors and the style of upbringing and parental attitude of the caregivers.

Young sees borderline personality disorder as on a continuum with multiple personality disorder. From clinical observations, the author drew conclusions suggesting that patients with BPD usually display all areas of maladaptive schemas. The original assumptions failed to explain the variability of affective states characteristic of the discussed disorder. This led to enriching the theoretical concept with the construct of schema modes. Currently, working with schema modes is seen as the essence of the treatment of profound personality disorders.

Young distinguishes five main schema modes characteristic of patients with borderline personality disorder:

- The Abandoned/Abused Child Mode – associated with the experience of suffering, emotional pain and harm.
- The Angry and Impulsive Child Mode – dominant in situations of experiencing needs deprivation. The emotional state characteristic of the mode is anger.
- The Detached Protector Mode – considered typical of patients' functioning. Combined with experiencing emotional numbness and emptiness. Closely related to such strategies as social withdrawal, excessive independence, substance use, daydreaming, compulsive behavior (e.g. binge eating), or stimulation seeking.
- The Punitive Parent Mode – associated with the internalization of devaluing, undermining, overly critical and punitive attitudes. It leads to a repetition of the experience of abuse. It manifests in self-criticism and destructive behavior, including suicidal tendencies.
- The Healthy Adult Mode – the least developed aspect of patients' functioning. It should fulfil a threefold role: to protect and affirm the abused child, to set realistic boundaries for the angry and impulsive child, and to moderate dysfunctional parenting modes.

Schema therapy assumes that the main goal of treating BPD is to internalize the healthy adult mode. With regard to the above postulate, it is recognized that the therapeutic process should last at least two years in order to create sufficient conditions for the effective modelling of adaptive attitudes. There are four categories of therapeutic interventions adapted to the assumptions of the active schema style model: 1) limited reparenting, 2) experiential strategies (mainly working with images and chairs), 3) cognitive techniques and psychoeducation, and 4) behavioral pattern-breaking [33].

The protocol of schema therapy in the treatment of borderline personality disorder consists of three stages that reflect the child's early mental development, i.e. bonding and emotional regulation, changing schema modes, and developing autonomy. At each of these

stages, all four change strategies, which are of key importance for therapeutic success, are used in different configurations [34].

The first reports verifying the effectiveness of BPD treatment based on the protocol of schema therapy appeared in 2005. They concerned a systematic analysis of the effectiveness of treatment applied to 6 patients diagnosed with a borderline personality disorder for a period of 36 months and a reassessment one year after the end of the therapeutic process. The results indicated a reduction in depressive symptoms and an improvement in psychosocial functioning in all participants of the study, both during therapy and during the evaluation study [35]. The above observations have been confirmed in other randomized studies conducted by independent researchers on various patient samples [19, 36]. Giesen-Bloo et al. compared the effectiveness of schema therapy interventions and transference-focused therapy, which proves that both methods of treatment bring a significant reduction in psychopathological symptoms specific to BPD, as well as improve the patients' quality of life. However, schema therapy turned out to be more effective in relation to all measures used [19]. Farrel, Shaw and Webber extended the therapeutic effects by 8-month group schema therapy, including 30 sessions, and then compared its effectiveness with the basic treatment protocol, obtaining a significant reduction in experienced symptoms. At the final stage of therapy, 94% of patients using the extended treatment regimen did not meet the criteria for the diagnosis of borderline emotionally unstable personality disorder [36].

Cognitive-behavioral therapy

Cognitive-behavioral therapy is a psychotherapeutic approach characterized by clear and precise treatment protocols and the largest base of empirical evidence confirming the legitimacy of its use in a wide range of mental disorders [37]. Conceptualizations of personality disorders began to appear two decades later than those created for affective or neurotic disorders. They assumed that the key cognitive schemas of patients with personality disorders are overly generalized, inflexible, absolute and resistant to change. Beck et al. based on theoretical models, created a list of dysfunctional beliefs characteristic of individual personality disorders. This list did not include borderline personality disorders. The authors suggested that the beliefs of patients diagnosed with this disorder go beyond the standard categorization [38]. In later years, the cognitive model was developed with new assumptions regarding the cognitive schemas characteristic of the borderline personality structure. Arntz hypothesized that these core beliefs of patients with borderline personality disorder have their aetiology in traumatizing childhood experiences, in particular emotional, physical, sexual abuse and neglect. This causes cognitive and emotional stagnation, which determines the most important assumptions and cognitive characteristics of patients. For this reason, he attributed significant importance in the therapeutic process to experiential strategies [39]. In further work, Arntz, Dietzel, and Dreessen proposed a list of 20 assump-

tions specific to people suffering from a borderline personality disorder, which concerned areas such as feelings of loneliness, dependence, vulnerability, inability to deserve love, feeling of emptiness, lack of inner sense of control, distrust [40]. Assumptions of Arntz et al. are consistent with the later conclusions of Butler, Brown, Beck and Grisham [41].

Arntz described the borderline personality disorder treatment protocol, which consisted of five stages of work: 1) building a cooperation strategy, 2) gaining control over symptoms, 3) correcting cognitive errors, 4) working on emotional processing of negative early childhood experiences, 5) maintaining progress [39].

The first randomized controlled trial conducted to assess the effectiveness of cognitive-behavioral therapy in the treatment of borderline personality disorder was the BOSCOT project (The Borderline PD Study of Cognitive Therapy). It compared the effectiveness of TAU treatment with TAU enriched with 30 individual therapeutic sessions based on the classic protocol of cognitive-behavioral therapy. Patients in the cognitive-behavioral therapy group reported fewer suicide attempts, less anxiety, and less dysfunctional cognitive content. The studies showed no significant differences between the groups in terms of the number of days of hospitalization, the frequency of self-injury or the level of interpersonal functioning [42]. Another comparative study on a group of patients diagnosed with borderline personality disorder showed that cognitive-behavioral therapy leads to faster improvement in the reported sense of hopelessness, lowering the level of impulsiveness and better assessment of the therapeutic relationship compared to client-focused therapy [43].

Conclusions

Considering the prevalence of borderline personality disorder, its course and the multifaceted, and negative consequences, the search for effective therapeutic interventions with high availability seems to be indispensable. Subsequent meta-analyses confirm the beneficial effect of psychotherapy on the severity and course of the disorder while pointing to the highest effectiveness of two therapeutic approaches, i.e. psychotherapy based on mentalization and dialectic-behavioral therapy [44]. Currently, DBT has the largest base of empirically established effectiveness. The results regarding the effectiveness of treatment based on schema therapy also seem promising, however, due to less than 15 years of practice in the implementation of this form of treatment for borderline personality disorders, there is still a lack of solid, unambiguous research proving its effectiveness. The models of understanding the genesis of BPD formulated in the cognitive-behavioral approach, and the transparent protocols of therapeutic interventions developed for them enable empirical verification. Multicenter, randomized controlled trials comparing the effectiveness of cognitive-behavioral therapies with TAU in the treatment of patients with borderline personality disorders are currently being conducted [45, 46]. The next step leading to a better understanding of the mechanisms underlying the improvement of mental well-being

of patients suffering from BPD is the identification of specific therapeutic factors. When analyzing the characteristics of psychotherapeutic processes conducted in the cognitive-behavioral approach, it can be assumed that the most important elements determining the effectiveness of the undertaken procedures include: 1) transparency of the theoretical models used, 2) a solid therapeutic relationship, based on the simultaneous acceptance of the patient and empathic confrontation, which motivates changes, 3) a wide range of techniques offered to the patient in order to improve the processes of emotion regulation and impulse control, 4) the possibility of contacting a therapist in crisis situations [19].

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