Impact of DBT vs. Alternative Outpatient Therapies

A Research Paper Presented to

The Facility of the Adler Graduate School

In Partial Fulfillment of the Requirements for

Master of Arts in Counseling and Psychotherapy

Adlerian Psychology

By:

Kyle Ross

December 2013
Abstract

Borderline Personality Disorder represents a difficult to treat personality disorder for multiple reasons such as; its development, course, diagnosis and effective treatment. Maladaptive behaviors are a cornerstone of BPD, and are defined for the purposes of this literature review as suicidal, parasuicidal and deliberate self-harming behaviors. The purpose of this literature review is to utilize concepts of holism from Individual Psychology, structure and comprehensiveness to evaluate the evidence based treatment of DBT from other existing outpatient models for BPD. The structure of this review will use an exploration of the development of each therapy and an evaluation of effective treatment of maladaptive behaviors.

Current evidence suggests that DBT is the most efficacious treatment of BPD. This review will explore alternative outpatient models of psychotherapy through the lens of Individual Psychology. The result is a practical and pragmatic comparison of DBT versus alternative outpatient therapy models.

*Keywords*: Borderline Personality Disorder, Dialectical Behavior Therapy, Individual Psychology, and Outpatient Therapy for BPD
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Acknowledgements

This writer would like to formally acknowledge the following individuals for their continued encouragement of myself over the course of graduate school, the writing of this literature review, and my work with clients. Their support has contributed to my personal and professional growth for which I am extremely grateful.

To my parents; Susan and Neil Ross who have selflessly and unwaveringly supported all of my dreams and aspirations without hesitation

To Debra Stack MA, LP; who is a truly wonderful mentor, supervisor, and friend who always encourages and supports growth personally and professionally

To Dr. William Premo; who has patiently guided me and numerous others in their journey as Adlerian therapists
The impact of Linehan’s Dialectical Behavior Therapy Versus Existing Out-Patient Therapeutic Models

Dialectical Behavior Therapy as a structured therapeutic model will have a more significant impact on the treatment of Borderline Personality Disorder than alternative outpatient models. Borderline Personality Disorder (BPD) is anecdotally seen in the mental health field as a highly difficult disorder to diagnose and treat effectively due to a high number of co-morbid factors and maladaptive behaviors based on perceived fear of abandonment. Maladaptive behaviors appear to be a catch all term related to symptoms stemming from any one of, or all nine criteria contained within the Diagnostic and Statistical Manual-IV-Text Revised. The manifestation of symptoms causes great difficulty in providing effective therapeutic services to individuals experiencing BPD. Suicidal ideation and suicide attempts are among the most challenging symptoms for individuals with BPD and the clinicians working with them. Carter, Willcox, Lewin, Conrad, and Bendit (2010) discuss that the DSM-IV-TR states suicide attempts are a criterion for BPD diagnosis, which indicates, “that suicidal behavior is a common accompaniment to this disorder” (p. 162). Additional symptoms include maladaptive behaviors which incorporate “criteria of which include suicidal attempts, threats and gestures, as well as impulsive behaviour, including deliberate self-harm” (Low, Jones, Duggan, MacLeod, & Power, 2001, p. 288). Each behavior makes it more difficult for clinicians to develop trusting and lasting relationships. The development of a solid and trusting therapeutic relationship allows clinicians to ultimately treat core personality trait components most effectively. Marsha Linehan’s Dialectical Behavior Therapy is a structured model, which will have a more significant impact on the conceptualization and treatment than alternative outpatient treatment models for Borderline Personality Disorder.
Statement of the Problem

This writer’s interest in effective treatment of BPD has risen due to personal exposure in the context of group homes, outpatient mental health programs, and personal involvement on several treatment teams when working with individuals with BPD. Psychiatric hospitalizations are commonplace for individuals diagnosed with BPD. The result of ineffective treatment is financially costly to the mental health system and causes the appearance of the primary criteria for BPD, perceived fear of abandonment from those providing care.

Significance and Purpose of the Study

The purpose of this literature review is to examine the effectiveness of Dialectical Behavior Therapy for maladaptive behaviors from individuals diagnosed with BPD. Maladaptive behaviors are the “chronic parasuicidal behaviour occurs in women with a diagnosis of borderline personality disorder” (Swales, Heard & Williams, 2000, p. 7) versus existing outpatient therapy models. Marsha Linehan designed DBT to address specific criteria and symptoms that equate to maladaptive behaviors clinicians often find difficult to treat, specifically suicidal behavior and parasuicidal gestures. This writer will explore and evaluate alternative outpatient treatments used to treat BPD in relation to using DBT for treating maladaptive behaviors. This literature review seeks to establish if Marsha Linehan’s Dialectical Behavior Therapy will have a greater impact on maladaptive behaviors of individuals experiencing Borderline Personality Disorder than alternative outpatient therapeutic models. A further examination of Interpersonal Psychotherapy, Rupture Resolution in Cognitive Analytic Therapy, Psychoanalytical, Mentalization Based Therapy, Pharmacology, Cognitive Analytic and Schema Therapy will reveal differences in effectiveness in outpatient therapies used for
BPD. This writer will use Adlerian terminology throughout this literature review and therefore is providing an Adlerian conceptualization of BPD.

**Research Statement**

Marsha Linehan’s Dialectical Behavior Therapy is a structured therapy model that will have a more significant impact on the conceptualization and treatment than alternative outpatient treatment models for Borderline Personality Disorder. Through collected research articles on the treatment of BPD using DBT and alternative outpatient therapy models this writer will analysis the data, and assess the efficacy of each treatment of BPD. After each therapeutic model is assessed in comparison to DBT this writer intends to show that DBT has the highest success rates with a difficult to treat disorder.

Evaluating the efficacy of various outpatient models provides clinicians with specific answers to the most prominently recognized treatments of a difficult disorder with statistical analysis from recent studies. Areas of interest and concern addressed in this literature review will focus on the effectiveness in treating maladaptive behaviors in individuals experiencing BPD with DBT versus outpatient therapy models. Outpatient therapies are defined as Pharmacotherapy, Rupture resolution in Cognitive Analytic Therapy, Psychoanalytic, Mentalization Based Therapy and Schema Therapy. Each therapy explored in effectiveness in treatment of BPD will provide condensed methodology and various forms of analysis. This literature is limited by utilizing thirty sources, and are mostly articles found through the Adler Graduate School search engine for professional psychology articles EBSCO, which are peer reviewed and are published in scholarly journals.
Definition of Terms

**BPD:** Borderline Personality Disorder: BPD is a personality disorder characterized by fluctuation in mood and affect, impacting the individual’s ability to develop and maintain interpersonal relationships. It is marked by impulsive behavior, intense and unstable interpersonal relationships, unstable self-image, feelings of abandonment and an unstable sense of self.

**CAT:** Cognitive Analytic Therapy: Explores attachment for the individual experiencing BPD as necessary, but not sufficient condition for normal development. Understanding an individual’s attachment, or lack thereof, assists in understanding how subsequent interpersonal roles are enacted.

**DBT:** Dialectical Behavior Therapy: DBT is a therapy created by Marsha Linehan to address chronic parasuicidal and suicidal behavior for individual’s experiencing BPD. DBT is a structured and time limited cognitive behavioral focused therapy.

**DSH:** Deliberate Self-Harm: Defined for the purposes of this paper as the intentional act of physically harming oneself when under duress stemming from dysfunctional cognitions.

**MBT:** Mentalization Based Therapy: A therapy designed and applied to assist client create a healthy mentalization about oneself, others, and relationships.

**MDD:** Major Depressive Disorder: A psychiatric illness, which is often recurrent in nature and characterized by loss of pleasure or interest, hopelessness and helpless thoughts, and sad or depressed mood.

**PTSD:** Post Traumatic Stress Disorder: Is an anxiety disorder generally following a traumatic or stressful event in which an individual continues to experience mental and physiological symptoms as if the event were happening again.
Schema Therapy: Schema Therapy was designed by Dr. Jeffrey E. Young, which identifies maladaptive schema, coping styles, modes, and how a person meets their basic needs.

Adler’s Conception of Neurosis

While Alfred Adler’s career and creation of Individual Psychology ended several decades ago, his approach to psychology and more specifically psychotherapy remains pertinent to understanding BPD. Adler’s career ended prior to the creation of the DSM, and therefore did not have access to the current terms clinicians find commonplace today such as BPD. It is this writer’s viewpoint that Adler would have used the term Neurosis. In the article by Gerald J. Mozdzierz (1996) he utilizes Adler’s definition as: “The distortions and mistaken attitudes (lacking community feeling) comprising one’s biased apperception represent the maladaptive character traits people develop and use in dealing with life’s obstacles when they lack the courage for more constructive, prosocial solutions” (p. 129).

Mozdzierz interprets Adler’s work as humans striving for solutions, some of which are maladaptive out of a fear of failure, which poses a threat to their personal well-being. Further, if individuals do not have the capacity for community feeling or social interest, they have no alternative but acting out in maladaptive ways to get their needs met. Without these attributes “they will literally have no other viable behavioral, psychological, or ideological choice to make or follow. Their solutions will be motivated by the pursuit of self-interested, egotistic goals” (Mozdzierz, 1996, p. 344). When the concepts of community feeling, striving, and social interest are combined with an Adlerian conception of maladaptive behavior, BPD characteristics have a more unified and clarified purpose. Mozdzierz’s definition of neurosis assists in coming to a more clear understanding of BPD, which to understand how they perceive the world, and that is their lifestyle.
Adler’s framework provides practicing clinicians with a construct, which encompasses a thread, which weaves behaviors, thoughts, and treatment together. Gemeinschaftsgefühl, meaning community feeling, can be viewed as the needed prosocial engagement in every human being life. This need is intensified by individuals suffering from neurosis in Adler’s terms, which this writer believes is discussing personality disorders, and aptly describes BPD. His defining features of neurosis are 1) have extraordinary bad social effects, 2) few of them are ever treated, 3) the person is afflicted throughout their life, and 4) the person suffers a burden and an immense torture. These definitions are similar to language used the DSM for personality disorders (Mozdzierz, 1996).

When viewing Adler’s writing about the neurotic person language becomes essential in understanding his definition, but also provides a link to understanding BPD and the treatment following. Mozdzierz provides an illustration of Adler’s views on neurosis, and a glimpse into an individual with BPD experience of the world:

Consider the words and linguistic expression that he used in his description of neurosis, and listen to the metaphors of his language. The reader can hear and feel powerful images which resonate and echo in human experience: “feeling(s)” of being “continuously threatened”; an “emotional state”; fear of a final defeat”; a deadly (authors depiction) “blow to one’s prestige”; a cognitive sate of mind characterized as “relentless”; a “battle—and I would correspondingly describe it as akin to an unending siege mentality; a superiority complex so strong that it is “viewed with a shuddering awe”; feelings, ideas, and actions totally devoted to “retreat”; “fear of a collapse of pride”; “manifestation of shock”; “an advance toward the rear not allowed to be interrupted, he recoils from the exogenic factor”; “impatience”; “the heightened emotion
of one living as if in an enemy country”; “greed”; “goes to pieces on the battlefield of life”; “a tide of feeling”; and so on. A person conducting life with such torment lives at the fringes of terror and exhaustion! (Mozdzierz, 1996, p. 347)

Implications of this description go beyond a mere understanding or empathetic view of individuals with neurosis or a personality disorder, but gives pertinent clinical information. If clinicians are more able to accurately diagnose BPD, and additionally apply a more accurate understanding of their lifestyle, a more full and effective treatment is likely.

In Adler’s book The Individual Psychology of Alfred Adler he describes what this writer’s bias would be called attachment to caregivers. He explores the process in which children strive to find comfort at an early age within their primary social context, their families. Adler states “Among the externally observable psychological phenomena in children, the need for affection (Zartlichkeitsbedürfnis) shows itself relatively early… We rather perceive in it the reflection of several tendencies, of open and unconscious wishes, and the expression of instincts which in part are strong enough to become conscious” (Adler, 1956, p. 39). The Adlerian conception of lifestyle states that a person’s core beliefs about the world are developed no later than the age of seven. These experiences children have shape their personality, and provide them with a framework in which to try and understand the world. Therefore each person’s lifestyle becomes the lens that they use to view the world. Each person’s unique lifestyle therefore becomes a road map for how to interpret, respond, and manage interpersonal and social situations. Every individual’s lifestyle therefore has biases built in based on their experience, and those bias’ can be directed to either the useful or useless.

The mental health community is in general acceptance that the development of BPD is closely related to early childhood experiences, particularly negative or traumatic experiences.
The close relationship of early childhood experiences and development of BPD is on
congruence with both Adlerian psychology and the foundations of DBT. Cartwright argues that
up to 80% of individuals with BPD have experienced early childhood trauma. The statistics
related to childhood trauma that Cartwright provides in combination with the Adlerian
conception of lifestyle is convincing evidence for practicing clinician’s a theoretical framework
of the core beliefs of individuals with BPD. Each person’s lifestyle contains basic beliefs
regarding the world, men, women, self, and relationships, and their lifestyle is reinforced and re-
experienced in social interactions. When an individual with BPD that has had early childhood
trauma experiences or re-experiences a difficulty in a relationship in which they tend to
withdraw, pull people closer, become angry, etc. Their behaviors are their responses based upon
their conception of the world, which in Adlerian terms is their lifestyle, and in clinical terms
their symptomology or pathology. The continuation of perceived negative experiences of their
core beliefs that other people should be feared because they will abandon you grows stronger
and more substantial over time, and in all areas of an individual’s life.

Alfred Adler further explores how an individual becomes neurotic, and it is this writer’s
bias that because BPD was not a term in Adler’s lifetime; a neurotic lifestyle is compatible with
the lifestyle of an individual with BPD. Symptoms are the framework in which a clinician
diagnoses a mental illness, and is the commonplace and communal language to explain
behaviors. While Adler’s vocabulary differs in 1913 compared to now, his definition of
safeguarding is relevant then and now;

All neurotic symptoms have as their object the task of safeguarding the patient’s self-
esteeem and thereby also the life-line (later, style of life) into which he has grown. To
prove his ability to cope with life the patient needs arrangements and neurotic symptoms
as expedient. He needs them as an oversized safeguarding component against the
dangers which, in his feelings of inferiority, he expects and incessantly seeks to avoid in
working out his plans for the future. (Adler, 1956, p. 263)

Adler espouses that there are three main tasks in life; love, work, and community which all individuals must engage in to maintain a healthy lifestyle. An individual who does not engage in these activities and questions of life due to their early childhood experiences may develop a lifestyle towards the useless. Individuals safeguarding mechanisms maintain the useless lifestyle based on their feelings of inferiority. It is this writer’s bias that: Safeguarding is the technique by which individuals with BPD escape the questions and tasks of life. Individuals safeguard their feelings of inferiority, and as Adler argues “But as human beings cannot endure this for long, the inferiority feeling stimulates them, as we have seen, to movement and action” (Adler, 1930, p. 100). These movements become predictable over time and therefore become the individual’s style of life. While BPD was not a formal diagnosis during Adler’s life his description of an individual whom avoids life tasks and attempts to keep others supporting them describes the lifestyle of BPD well.

What happens in the case of a person whose goal is to be supported by others? Hesitating, he stops or escapes the solution of the questions of life. We know how he can hesitate, stop, or escape, because we have seen the same thing happen a thousand times. We know that he does not want to proceed alone but wants to be pampered. He wants to stay far away from the great problems of life, and he occupies himself with useless things rather than struggle with the useful ones. He lacks social interests, and as a result he may develop into a problems child, a neurotic, a criminal or a suicide-that final escape. All these things are now better understood than formerly. (Adler, 1930, p. 101)
Understanding Dialectical Behavior Therapy: Implication and Context

Individual’s experiencing BPD have become synonymous with the idea that they are difficult to work with and treat. Such beliefs are why the mental health community has seen a rise in a popularity of utilizing DBT methods to treat BPD patients. Recent studies have validated original findings regarding DBT. This literature review will explore the stages and modalities used within DBT as structured evidence based treatment for BPD. As high as 6% of the general population, 8-11% of outpatient therapy recipients, and 20% of inpatient mental health service recipients are believed to have BPD (Rizvi, Steffel, & Carson-Wong, 2012). An article by Rizvi et al. (2012) indicated “It is unlikely that a practicing psychologist can avoid working with individuals with BPD and such work is often stressful” (p. 1). A clinician’s ability to holistically treat BPD must include a holistic understanding of the disorder and potential causes of difficulty in treatment. Trauma is a highly associated term with BPD with much emphasis on potential sexual abuse at an early age. “A further investigation into the childhood histories of the self-harming women within Rampton revealed that 80% of those women who harmed themselves frequently (more than once a month) had experiences of sexual abuse” (Low et al., p. 287).

Dialectical Behavior Therapy

DBT was formed out of a Cognitive Behavioral Strategy that contains four stages designed to address five functions intended to work with individuals in an outpatient setting (Rizvi et al., 2012). The four stages can be understood by the mode in which they are utilized and are as follows: 1) individual therapy, 2) skills training, 3) outside of session consultations between client and therapist, and 4) therapist consultation in team meetings. These stages are directly designed to address the following areas; a) motivation to change, b) enhance client’s
capabilities, c) generalize gains to larger environment, d) structure environment to reinforce change, and e) increasing therapist motivation and competence (Rizvi et al., 2012). Authors Swales et al. (2000) expand each stage within DBT and its specific use, which is illustrated by, “Each target in the hierarchy should be as behaviorally defined as possible,” (p. 12) for example, “the therapist would not identify ‘client resistance’ as a problem” (p. 12).

The core of DBT has three subcategories; biosocial, behavioral theory, and dialectical philosophy. Each subcategory is Linehan’s assertion as to how core features of BPD are created and thus result in behaviors meeting criteria for BPD, the most prevalent being emotional dysregulation from interpersonal social contexts. Authors Murphy and Gunderson (1999) provide a practical explanation of how these subcategories interplay in their article “A Promising Treatment for Borderline Personality Disorder.”

**Biosocial theory.** DBT is based on a biosocial theory of personality functioning in which BPD is seen as a biological disorder of emotional regulation. The disorder is characterized by heightened sensitivity to emotion, increased emotional in-tensity and a slow return to emotional baseline. Characteristic behaviors and emotional experiences associated with BPD theoretically result from the expression of this biological dysfunction in a social environment experienced as invalidating by the borderline patient. (p. 1)

In the article “A Biosocial Developmental Model of Borderline Personality: Elaborating and Extending Linehan’s Theory” (2009) authors Crowell, Beauchaine, and Linehan explore the etiology of BPD by stating “One probable pathway is identified that leads to borderline personality disorder; it begins with early vulnerability, expressed initially as impulsivity and followed by heightened emotional sensitivity. These vulnerabilities are potentiated across
development by environmental risks factors that give rise to more extreme emotional,
behavioral, and cognitive dysregulation.” The author’s research for this article clearly articulates
an interwoven set of risk factors to the contribution to the board term of developmental
psychopathology. It is a dynamic set of events and cognitive processes that include “genetic,
neural, behavioral, familial, and social” factors. Biosocial theory has limited studies conducted
to prove its validity, but remains the prominent theory in understanding the underlying factors
influence the development of BPD. Biosocial theory as explored by Linehan has similar
theoretical underpinnings the Individual Psychology of Alfred Adler. In Adler’s “The Progress
of Mankind” he explores how people interact with themselves and their environment “Decisive
for his behavior is the individual’s opinion of himself and the environment with which he has to
cope. Individual Psychology assumes the further the individual’s striving for success in the
solution of his problems, this striving being anchored in the very structure of life.” Adler’s
arguments and biosocial theory explore the individual’s social, environmental, and interpersonal
context of how a person perceives situations. It should be noted that in Adler’s lifetime limited
knowledge was known concerning genetic components, and therefore do not contain those
qualities contained with biosocial theory.

Authors Cheavens, Strunk, and Chriki (2012) explore the theoretical foundations of BPD
in their article “A Comparison of Three Theoretically Important Constructs: What Accounts For
Symptoms of Borderline Personality Disorder?” They explore biosocial, attachment and
interpersonal, and psychodynamic theory. In contrast to biosocial theory there are two other
prominent theories to explain how BPD is developed and maintained, which are attachment and
interpersonal theory and psychodynamic theory. In short attachment and interpersonal theory
maintain that BPD is developed through problematic relationships throughout the
developmental lifespan of an individual. Psychodynamic theory “focuses on the lack of an integrated sense of self.”

An invalidating environment is another core feature that is critical to define an understanding in the development and effectiveness of DBT. Rizvi et al. (2012) stated, “The invalidating environment is defined as one that pervasively invalidates an individual’s communication of internal experiences, including emotions” (p. 2). The theory of an invalidating environment provides suggestive correlations between the creation of BPD and the difficulty in treating the disorder due to the manifestations of maladaptive behaviors.

The second theory behind the formation of DBT is behavior theory, which defines behavior as “anything an individual does, and includes thoughts, feelings, and overt actions” (Rizvi et al., 2012, p. 2). This definition of behavior is broad by design to include both adaptive and maladaptive actions. By including thoughts into the theory of behavior, direct implications influence on how individuals, specifically those with BPD, perceive problems. In effect, DBT shapes and increases adaptive behaviors and decreases maladaptive behaviors. An Adlerian perspective views this shaping process as the increase in useful versus useless actions or behaviors. DBT’s behavioral theory posits, “every behavior is caused” (Rizvi et al., 2012, p. 3). Thus, the association’s specific behaviors can be identified and shaped into more useful actions.

The third element in the construction of DBT is dialectical theory, which states “reality is interrelated and connected, made of opposing forces, and always changing” (Rizvi et al., 2012, p. 3). This theory is utilized when the therapist and BPD client reach a point in the process in which they become stuck. The therapist believes and voices opposing views as a therapeutic technique to assist BPD individuals to become unstuck. On one hand the client states wanting to make positive changes in their lives while at the same time reporting they will
not change. Dialectical theory holds simultaneous views can be held and both are valid. When the therapist states the clients opposing views, they are searching for the truth from the client in each side (Rizvi et al., 2012).

All three theoretical foundations of invalidating environments, behavior theory and dialectical theory are incorporated and structured into a linear framework. For example, DBT is provided through individual therapy, group therapy. Therapists providing such services use supervision as a way to increase their skills and prevent burnout. This framework is further broken down into stages, which provide suggestive guidelines to therapists providing services. The framework is broken down into four stages: 1) behavioral discontrol, 2) attend to feelings of misery, 3) increasing self-respect and quality of living, and 4) address self-awareness and incompleteness (Rizvi et al., 2012). Each stage corresponds to severity of maladaptive behaviors that threaten injury to self and others. Skill-building group sessions last approximately two and a half hours for six months every week, while individual therapy can last much longer. Phone coaching is an as-needed approach for decreasing instances of self-harm. Supervision groups for therapists are suggested to last 60-120 minutes once a week (Rizvi et al., 2012).

DBT provides a highly structured framework in which individuals with BPD are treated comprehensively by multiple therapists in a multi-modal manner. DBT provides a systemic approach for addressing needs from a basic safety level, to a higher complexity level of self-awareness and life satisfaction. Additionally, focusing on therapist’s well being in an integrated method, providing learning and avoidance of stress in their work with clients. Not every mental health professional has the ability to provide DBT in the model designed by Linehan for multiple reasons, such as logistics, cost and client preferences. It has been argued that the full design by Linehan does not have to be offered for clients to benefit from it, therefore DBT can
be offered for individual and group settings. In the article “Effectiveness of Combined Individual and Group Dialectical Behavior Therapy Compared to Only Individual Dialectical Behavior Therapy: A Preliminary Study,” the efficacy of individual DBT versus individual and group DBT is compared. The article bases results on several outcome measures such as suicide attempts, self-harm behaviors and emergency room visits. Assessments were completed at time of pre-treatment, twelve months or end of treatment, and again eighteen months (Andion et al., 2012). The article provides suggestive results in that post-treatment assessments yielded no significant differences.

The method of studying individual DBT treatment versus individual and group DBT treatment was within the model that Linehan proposed. Following is the methodology utilized in Andion et al. study (2012):

The study was conducted with 53 BPD outpatients who had been consecutively admitted to the BPD Treatment Program, consisting of 51 women (96.2%) and 2 men (3.8%). As only 2 men agreed to participate in the study, they were not included in the study in order to reduce sample variability. The patients were aged between 18 and 41 years (M = 25.63, SD = 6.46). Most of the patients had completed primary school (n = 43; 84.3%), whereas only 8 of them (15.7) had completed high school. Thirty-nine patients (76.5%) were single, only 9 (17.6 %) were employed, and 15 (29.4%) were students. (p. 241)

Additional statistical data was collected for maladaptive behaviors defined as at least one suicide attempt, and at least one self-harm behavior and psychiatric emergency department visit. Self-harm behaviors were defined as intentional harm to self without the intention of dying. Further additional, data such as co-morbid disorders, medications taken, and substance
abuse were also tracked. The 40 patients who partook in the twelve-month treatment as well as the twelve-month end interview determined analysis of data by using the “Structured Clinical Interview for DSM-4 Axis 2 Disorders” (Andion et al., 2012).

The result of Andion et al. (2012) study showed no significant differences between co-morbid disorders on Axis one, but did show those receiving only individual versus individual and group DBT as older in age by a standard deviation of 6.86. A reduction in the three maladaptive of suicide attempts, self-harm and emergency room visits were observed by utilizing the McNemar test. Suicide attempts at the twelve-month assessment statistically recorded as \( p = .27, d = 0.067, 95\% \text{ CI } [-2.07, 1.92] \). Self-harm behaviors were tracked at the twelve-month assessment as \( p = .29, d = -0.70, 95\% \text{ CI } [-0.58, 0.67] \). The number of emergency room visits was tracked at the twelve-month assessment as \( p = .85, d = 0.13, 95\% \text{ CI } [-1.14, 1.39] \). Clients who stopped treatment were not added to statistical data tracked. The results of this statistical analysis are a reduction from pretreatment of suicide attempts to 69.2% and a 75% reduction in self-harm behaviors (Andion et al., 2012).

The authors summarize significant findings of this study; “Our results are similar to those observed in previous DBT studies that have analyzed the reductions in suicide attempts, self-harm behaviors, and the number of visits to emergency departments” (Andion et al., 2012, p. 248). While there are limitations of this study in number of clients, the medications clients took, and the lack of male participants, there remain significant implications for the efficacy of DBT treatment. The implications supported by the author’s research validate similar findings in other research conducted on BPD; a significant reduction in the amount and frequency of self-harm behaviors, suicide attempts, and use of emergency services. Practicing clinician’s who work with the BPD population often assist the client in their management or elimination of
maladaptive responses to life circumstances. Maladaptive behaviors in the form of symptoms are exhibited by individuals with BPD often include instances of self-harm, suicide attempts, and use of emergency services. Therefore this supporting research providing convincing evidentiary support of DBT’s behavior modifying affect on BPD symptomology.

Deliberate Self Harm presents to clinicians in multiple contexts when treating BPD, and therefore must be assessed within each of those contexts. Authors Low et al. (2001) have conducted a study of twenty-three adult women with BPD within a high security psychiatric setting with DBT. As explained by the authors, “We assessed the efficacy of DBT in a high security psychiatric setting, where deliberate self-harm is particularly common among the women patients” (Low et al., 2001, p. 287). Specific treatment strategies were based upon Linehan’s original model and focused on the following case illustrations throughout the treatment process. Dialectical strategies within the study were defined as balancing treatment with ideas of acceptance and change, flexibility and stability, and focusing on abilities and limitations. Core strategies were defined as behavioral skills and exposure based practices within a cognitive modification framework. Stylistic strategies were those based upon the therapist’s ability to provide a balance between empathy, irreverence and confrontation when determined necessary (Low et al., 2001).

The main assessment utilized was the International Personality Disorder Examination (IPDE), and was administered to 23 adult females who met inclusion data for BPD based upon the DSM-3-R. Of the 23 referred 15 were determined to be suitable for treatment as each female had a recent incidence of DSH. All 15 individuals were assessed at baseline, four-month intervals, and a six-month follow up with a “comprehensive battery of tests” (Low et al., 2001, p. 287). In each of the three illustrated cases from the 15 clients within Low et al. (2001),
themes emerge through statistical data by tracking ratings of self-esteem, inward irritability, outward irritability, depression, anxiety, hopelessness, suicide ideation, Beck’s Depression Inventory, impulsiveness, dissociative experiences and survival and coping beliefs. During the assessments at four months, eight months and twelve months, each individual had an increase in self-esteem, survival and coping beliefs. Instances of dissociation, anxiety, depression, suicide ideation, and impulsiveness decreased during the course of treatment (Low et al., 2001).

Limitations of this specific study are the limited number of cases examined, environment and the exclusion of men with BPD. Although these limitations exist, the data provides specific indications for in reductions maladaptive behaviors and increases in adaptive coping strategies. Further, the case illustrations provide practicing clinicians with stylistic and environmental limitations strategies to implement DBT. Several limitations were explored within the article, of special interest is using DBT in a high security setting for individuals with severe behaviors even within the context of BPD. While the high security environment was a limitation in the study, it unintentionally generalized the efficacy of DBT in extreme situations that provides additional credence to its use outside those limitations. In each case the individual benefitted during the course of twelve months of therapy, but regressed slightly during the six month follow up.

A specific complication in the treatment of BPD is deliberate self-harm and suicide attempts. Carter et al. (2010) explained, “Although 10% will eventually complete suicide, this outcome is not readily predictable, and hospitalization is of unproven value for suicide prevention, possibly producing negative effects” (p. 163). The article “Hunter DBT Project: Randomized Controlled Trial of Dialectical Behavior Therapy in Women with Borderline Personality Disorder” was designed to investigate the correlation between DBT and control
condition of treatment for Deliberate Self-Harm events. Additional gains of the study were to determine effects upon disability and quality of life. Each member of the team administering DBT was trained using Linhean’s training manual and were psychologists, social workers, therapists and psychiatrists by trade.

Carter’s research is based on clinical trails with 112 clients who were referred for the project, only 76 of them participated and of those 76 clients, 38 engaged in DBT versus 35 who did not. The results of the study found less significant differences in relation than numerous similar studies on the criteria of self-reported DSH, hospital treated DSH’s, or psychiatric hospitals. There was a wide range of assessment utilized in Carter’s research, which were implemented throughout the project in specified timeframes for each participant.

The course of trial of 79 clients lasted twelve months in which several assessments were completed at pre-treatment, four months, eight months and twelve months during the administration of DBT. Assessments were completed three months and six months after treatment. The assessments used were the International Personality Disorder Examination Questionnaire (IPDEQ), Composite International Diagnostic Interview (CIDI), Brief Disability Questionnaire (DBQ), Parasuicide History Interview – 3-month period (PHI-2), World Health Organization (WHO), and the Quality of Life-BREF version (WHOQOL-BREF) (Carter et al., 2010). The research conducted is summarized as follows;

There was considerable improvement in both the DBT and the TAU+WL control groups from the baseline levels. Even though the present study did not replicate the benefits of the reduction in DSH behavior and hospital admissions found in other studies [7,10], several secondary outcomes (disability and quality of life) showed clinically significant benefits in favour of DBT. (p. 172)
The consistency in which the assessments were used further supports the clinical evidence provided; not only that DBT is an effective treatment of BPD’s presenting problem of deliberate self-harm, but also the quality of life of individuals diagnosed with BPD. The design of the research of this study is comprehensive in several capacities such as; the amount and breadth of assessments, the structure and timeframes of the assessments, and the specific measurements of crucial maladaptive behaviors. The findings of Carter’s research provides crucial and useful data for practicing clinicians who are likely to have contact with individuals with BPD in their practice settings. Although the Hunter Project does not support identical findings of similar studies, it does however provide strong indications to alternative areas of support DBT provides. It is also suggested that the clinical findings were not as the hypothesis predicted. This implies that alternative benefits of DBT exist and several variables influence the efficacy of treatment.

Dialectical Behavior Therapy Summary

Dialectical Behavior Therapy provides a construct that links Eastern cultural elements of mindfulness in combination with Western Cognitive Behavioral Therapy for suicidal and parasuicidal clients. DBT is structured in a twelve-month timeframe, which includes individual therapy, group skill building, and therapist case consultation and encouragement. DBT is designed to be both holistic in nature and intended for outpatient settings. Individual sessions provide cognitive behavioral strategies for a difficult to treat population like BPD. Group sessions provide an arena for individuals to provide peer guidance, validation and practice space in a safe setting. A recently conducted study provides indications that individual sessions, when compared to individual and group sessions are equally as effective and significantly lowers the cost of providing DBT (Andion et al., 2012). In the Hunter Project’s (2009) randomized study
maladaptive behaviors of suicide attempts, DSH’s and emergency department visits did not substantially decrease. The Hunter Project provided data substantiating structure for individuals with BPD resulting in significant improvements in daily functioning through a multitude of psychological tests.

From the article “Dialectical Behavior Therapy as a Treatment for Deliberate Self-harm: Case Studies from a High Security Psychiatric Hospital Population” independently practicing clinicians are able to see how the specific maladaptive factors constituting BPD are affected throughout the course of twelve months of DBT. The data from the case studies provide hopeful evidence in severe cases of BPD for treatment outcomes, which provides suggestive outcomes for less severe cases.

**Borderline Personality Disorder**

Borderline Personality Disorder affects approximately 6% of the population and is characterized by core elements of high interpersonal conflict, suicidal and parasuicidal behavior, and fluctuation between idealization and demonization (Rizvi et al., 2012). While prevalence rates of BPD differ, Cartwright (2008) states psychiatric outpatients with BPD are between 8%-11%, inpatients are between 14%-20%, and forensic samples are between 60%-80% (p. 429). Anecdotal evidence within the mental health field perceives that women are primarily affected by BPD, which supports Cartwright whom stated, “In clinical populations 70% to 80% are women” (p. 429). In the article “Borderline Personality Disorder, Bipolar Disorder, Depression, Attention Deficit/Hyperactivity Disorder, and Narcissistic Personality Disorder: Practical Differential Diagnosis” the author identifies the first difficulty in working BPD, which is diagnosing correctly. Authors Kernberg and Yeomans (2013) accurately identify that “The challenge of accurate diagnosis remains at the heart of good psychiatric treatment” (p. 1).
With the prevalence rates of BPD, even at estimated samples depending upon various authors, clinicians will more than likely work with clients with BPD. Additionally, clinicians can face added difficulty due to factors of high irritability, comorbidity, lack of commitment, and personal burnout. An Adlerian conceptualization provides a holistic view of BPD that is applicable regardless of a clinician’s theoretical approach. Duncan Cartwright (2008) stated in an article, “Personality disorders (PD’s) were more powerful predictors of quality of life than socio-demographic variables, Axis 1 disorders, and somatic health” (p. 433). Diagnosis and core symptoms are crucial, not only understanding the diagnosis of BPD, but in its treatment regardless of the specific therapy framework used. Beginning with diagnosis, Cartwright quotes the DSM as, “The DSM-4-TR defines BPD as a pervasive pattern of instability in self-image, relationships, affects and impulsivity beginning in early adulthood” (Cartwright, 2008, p. 433). The DSM-5 (2013) defines BPD as; “The essential features of a personality disorder are impairments in personality (self and interpersonal) functioning and the presence of pathological personality traits. To diagnose borderline personality disorder, the following criteria must be met” (p. 663). The DSM-5 breaks down categories for diagnosing of; identity, self-direction, interpersonal-functioning, empathy, intimacy, negative affectivity, emotional liability, anxiousness, separation insecurity, depressivity, disinhibition, risk-taking, and antagonism. This writer is bias toward the breakdown in categories of DSM-5 for diagnosing BPD due to the ability of the clinician to more accurately differentiate functioning levels within the specific categories.

Cartwright (2008) delivers a unique perspective on the diagnosis of BPD, “For the diagnosis of BPD five of the nine criteria need to be met. On paper this means that there are 256 different combinations possible in order to be diagnosed with BPD” (p. 430). The variability
how an individual is diagnosed potentially illuminates suggestive issues in comprehensive treatment of the disorder. Further complicating effective treatments are behavioral traits, which are agreed upon by several clinicians as affective instability, intense anger, impulsivity and affect regulation (Cartwright, 2008). Due to the current understanding of the disorder many of these behaviors will not only be verbalized by clients, but also acted out in sessions. Other behaviors not contained within the nine criteria for a BPD diagnosis are the use of primitive defense mechanisms and regression (Cartwright, 2008).

In the article “Beyond Splitting: Observer-Rated Defense Mechanisms In Borderline Personality Disorder” sampled 25 BPD clients were sampled during interviews using a psychodynamic paradigm for defense mechanisms. Clinicians used the Defense Mechanisms Rating Scales (DMRS) to assess for the presence of defense mechanisms. Findings indicated BPD clients used “higher percentages of action, borderline, disavowal, narcissistic, and hysteric defenses, along with lower levels of mature and obsessional defenses” (Kramer et al., 2012, p. 3). From a theoretical therapeutic standpoint, interactions must stem from a core of five defense mechanisms that make up BPD personality traits. These are instability, which are devaluation, omnipotence, idealization, projective identification, and splitting (Kramer et al., 2012). These trait instability factors create the core of a BPD individual’s lifestyle in Adlerian terms. In a pragmatic sense as explained by Kramer et al., “such patients relate to other in unpredictable fashion, as though their image of the other person is drawn one moment from a library of good representations, and the next as though from a library of bad representations” (p. 4).

Each defense mechanism protects BPD individuals from an unwanted, misunderstood, or a learned skill, thus making it both a useful and useless behavior in one. Each use of a defense mechanism tends to reenact a traumatic experience and reinforces its use while
continually necessitating its use, leading to further deterioration of general functioning for the BPD individual (Kramer et al., 2012). Authors Hopwood and Zanarini (2010) in their article “Five-Factor Trait Instability in Borderline Relative to Other Personality Disorders” the authors tested previous findings of the five-factor trait instability of individuals with BPD, which yielded consistent results. Hopwood and Zanarini’s (2010) study states, “Results are consistent with previous findings in showing lower differential (rank-order) stability on conscientiousness, greater mean-level decreases on neuroticism, lower individual-level stability on conscientiousness, and lower ipsative stability of trait profile configuration” (p. 58).

Two elements practicing clinicians have likely noticed, but Cartwright explores are the course and stability of BPD. Personality disorders must be understood as a pervasive pattern of instability, but three features have been refuted by current research. First, remission of BPD has been found to occur at a much faster rate than previously thought, second, clinical features rapidly fluctuate over time, and third, some aspects of BPD are more dependent on situational factors than previously thought (Cartwright, 2008).

Comorbidity is common with most Personality Disorders and therefore becomes important in how clinicians conceptualize comorbid features during the treatment of BPD. A conceptualization, which is useful, is to view PD’s as an exaggerating influence upon Axis 1 conditions, due to both stemming from a common origin of vulnerability (Cartwright, 2008). BPD most commonly occurs with a prevalence of 70-90%, mood disorder anxiety disorders at 80% (mainly PTSD 55%), and substance abuse and eating disorders corresponding at 61% and 53% (Cartwright, 2008). There is no current causal link between the early childhood development of PD’s and comorbid conditions although it appears to exist without being yet clearly defined (Cartwright, 2008).
Due to commonality of comorbid disorders, and specifically mood disorders, differential diagnoses is critical in avoiding misdiagnosing individuals. Bipolar disorder is a common differential diagnosis when assessing for BPD and although genetic predispositions are similar, it is wrongly assumed to be a common comorbid feature. This illuminates potential reasons for anecdotal evidence of many individuals with BPD having a history of Bipolar Disorder (Cartwright, 2008). Kernberg and Yeomans (2013) states that “In about 19% of patients with borderline personality disorder, however, a comorbidity with bipolar disorder may be present, and the patient shows both severe, chronic affective instability and clear hypomanic episodes” (p. 3). The 19% of BPD clients with comorbidity presents a difficulty in accurate diagnosis and treatment, but remains a pertinent statistic for clinicians to keep in mind.

Depression symptomology is a common feature in which BPD individuals may seek treatment such as therapy, counseling, or are hospitalized. It is noteworthy that hospitalizations are not necessarily a useful intervention for experienced symptoms and heavily relies upon quality of psychological assessments completed with BPD individuals at the time (Cartwright, 2008). When treating depression symptoms within BPD individuals, antidepressants do not respond as well as Major Depression Disorder proper, thus indicating further importance upon correct diagnosis (Cartwright, 2008). Kernberg and Yeomans (2013) add additional insight into differentiation between depression symptoms within BPD and MDD. Kernberg and Yeomans (2013) stated, “Patients who present chronic suicidal and parasuicidal behavior without depression require highly specialized psychotherapeutic treatment. Many of these patients may be helped effectively with an integrative cognitive-behavioral treatment (Dialectical Behavior Therapy; Linehan, 1993)” (p. 9). Differentiation and delineation between individuals with suicidal ideation and suicidal attempts helps distinguish between individuals with MDD.
experiencing similar symptoms and BPD. Hospitalizations may not be the best practice for suicidal BPD individuals, but outpatient cognitive-behavioral strategies, such as DBT, are supported in their efficacy.

The DSM-5 states that “Borderline personality disorder is diagnosed predominantly (about 75%) in females,” (2013) yet a further distinction is made when research examines the prevalence rates of individuals with BPD and substance use. Cartwright (2008) noted “Substance abuse is typically found more frequently in male borderline patients” (p. 436). Substance use is a significant factor in predicting the remission of BPD, which stems from the absence or remission of substance use. Cartwright (2008) further explains “These factors appear to support clinical decision-making that aims to address substance use disorders aggressively before BPD treatment” (p. 436). Indeed a number of BPD programs exclude patients diagnosed with substance use disorders until substance use is controlled” (p. 436).

Trauma is a significant factor in the treatment of BPD. This writer defines trauma in terms of physical, sexual, emotional, and neglect of individuals in their worldview. This implies that trauma is defined by the individual’s own perception. Since upwards of 80% of individuals diagnosed with BPD have experienced trauma at an early age, and continue to experience ongoing trauma, the Adlerian conceptualization of lifestyle provides a framework into clinical application. Cartwright (2008) explains “individuals with BPD report higher rates of trauma in their early history. Sexual abuse appears to be consistently reported more frequently in BPD groups” (p. 432). The impact of sustained trauma has been shown to affect individual’s neurobiological make-up, thus affecting their interaction with the world in a pervasive manner (Cartwright, 2008). An exploration of a commonly thought of comorbid disorder of PTSD further assists in providing effective treatment of BPD. Kernberg and Yeomans (2013) stated:
Potential confusion between BPD and PTSD derives from the fact that traumatic experience or ongoing, repeated traumatization, which can be sexual, physical, or psychological, particularly in early childhood, constitutes an important etiological factor in the development of a severe personality disorder, particularly borderline personality disorder. (p. 14)

The distinction that Kernberg and Yeomans (2013) argue is that early childhood trauma for individuals with BPD assists in the development of the disorder itself, in contrast to PTSD in which the event and symptoms necessitate a different course and treatment. From a statistical standpoint BPD may be less common than anecdotally thought, “that only 20% of individuals with a history of serious abuse go on to have serious psychopathology as adults” (Kernberg & Yeomans, 2013, p. 15). If only one in five BPD individuals have PTSD symptoms the course of treatment must delineate which disorder is primary for effective treatment, thus changing the course of treatment.

Given several core-factors contributing to diagnosis, course and treatment of BPD, practicing clinicians must utilize this knowledge in application, which will consistently present itself in treatment attitude and treatment outcomes. A significant factor in successfulness of the treatment of all disorders is client expectancy. Client expectancy “is defined as a client expectation pertaining to the length and procedure of treatment, the role of the therapist, and whether treatment will lead to change” (Wenzel, Jeglic, Levy-Mack, & Brown, 2008, p. 250). Treatment alliance is a sub-factor within client expectancy and this writer defines it as therapists and clients collaboratively working on mutually agreed upon goals specific to BPD. Therapeutic alliance utilizes both the therapist’s formal training in the treatment of psychiatric disorders and the client’s unique knowledge, and personal experiences. In the study “Treatment Attitude and Therapy Outcome in Patients With Borderline Personality Disorder” correlations were found
between client expressions of problems, suicidal ideation and depression as evidenced by “more positive attitudes toward talking with a therapist about one’s problems were associated with less depression and suicide ideation 12 months later” (Wenzel et al., 2008, p. 250).

**Borderline Personality Disorder Summary**

Borderline Personality Disorder is a complex personality disorder that can severely alter general personality functioning for individuals while proving difficult for clinicians to diagnosis and treat effectively. Patients with BPD exhibit behaviors that fluctuate between idealization and devaluation during brief periods of time. Traits such as interpersonal conflict, emotional dysregulation, affect dysregulation and disturbances in identity prove uniquely difficult to diagnose and therefore treat. Individuals with BPD have a high correlation with comorbid disorders such as mood disorders, other personality disorders and substance abuse. Literature on the course of BPD appears to be incomplete at this time. When using the Five-Factor model of trait instability, the course of BPD has high levels of narcissistic tendencies; hysterical and obsessional features complicating a clear understanding of the true nature of its course. Understanding the criteria as well as the core factors constituting BPD requires practicing clinicians to have, at the very least, a rudimentary knowledge of diagnosis, course, and applicable treatment. While BPD individuals represent approximately between 2-6% of the general population, it makes up 8-11% of outpatient therapy, 14-20% inpatient, and forensic sample are 60-80% (Cartwright, 2008). It is unlikely that a practicing clinician is able to avoid working with individuals experiencing BPD and therefore necessitates knowledge of it. While BPD is commonly thought to have significant comorbid factors, recent studies have found that understanding the etiology is tantamount to success.
Outpatient Therapy Models Used for Borderline Personality Disorder

Various outpatient therapies have been used, designed, adapted or tailored for the specific use of treating BPD, and subsequent maladaptive behaviors. Effectiveness of such therapies provides clinicians with invaluable information in the treatment of individuals with BPD in outpatient setting. Of such studies Bellino, Rinaldi and Bogetto (2010) conducted a study with fifty-five clients with “a single diagnosis of BPD” (p. 74). Clients were randomly assigned into two treatment groups for duration of thirty-two weeks. The first receiving fluoxetine 20 to 40mg per day, and the second receiving fluoxetine 20 to 40mg per day in addition to Interpersonal Psychotherapy adapted to BPD. Since eleven clients dropped out of the study forty-four completed the study adding to statistical analysis. Data for analysis were collected at baseline, week sixteen and week thirty-two using a variety of collection methods. The Clinical Global Impression Scale (CGI-S), Hamilton Depression Rating Scale (HDRS), Hamilton Anxiety Rating Scale (HARS), Social and Occupational Functioning Assessment Scale (SOFAS), BPD Severity Index (BPD-SI), and a quality of life satisfaction scale were utilized as collection methods for the authors study. The authors note that $P$ values of less than 0.05 were considered significant (Bellino et al., 2010).

The study delineated Interpersonal Psychotherapy’s use between clients with Major Depressive Disorder and a diagnosis of BPD, and clients solely with a single diagnosis of BPD. The authors provide a historical background stating that “Concerning IPT, although it was initially developed by Klerman et al to treat major depression, some investigators have successfully extended its indications to other psychiatric disorders” such as BPD (Bellino, Rinaldi, & Bogetto, 2010). IPT was provided to clients over eight months, which equated to thirty-two total sessions. Additionally ten-minute once-per-week phone contact was provided to
minimize the potential for therapeutic ruptures. Through the screening process it should be noted that patients were excluded if they receive psychotropic drugs in the last two months, and if they were not “using an adequate method of birth control” (Bellino et al., 2010, p. 75).

Twenty-eight patients received single pharmacotherapy and twenty-seven received combined therapy of pharmacotherapy and IPT-BPD (Bellino et al., 2010).

The results of this study indicate no significant difference between the two groups when a statistical analysis was completed using the Pearson chi-square test. The results show that P=0.55, indicating no significant correlation. As the authors indicate “Both time and treatment factors showed a significant effect (respectively, P < 0.001 and P = 0.006) on the HARS; it means that both treatments were efficacious, but combined therapy was superior to single pharmacotherapy in improving anxiety symptoms” (Bellino et al., 2010). The results indicated that IPT has the potential to be a beneficial approach due to the comorbidity factors associated with BPD.

Therapists working with individuals with a diagnosis of BPD will likely encounter ruptures, which are defined as “an emotional disconnection between client and therapist that creates a negative shift in the quality of the therapeutic alliance” (Daly, Llewelyn, McDougall, & Chanen, 2010, p. 273). Ruptures have the potential for change, either positive or negative events during the course of therapy with clients with BPD. The authors further provide a nine-stage model in which to evaluate rupture resolution with adolescents within Cognitive Analytic Therapy (CAT). Therapeutic alliance is the core feature, which has the potential to facilitate successful treatment or premature client dropout. Rupture resolution is heavily dependent upon therapist’s utilization “inclusion of stages of the model, providing validation for the model, and
demonstrating that effective rupture resolution might be related to treatment outcomes” (Daly et al., 2010, p. 282).

The nine stages of Rupture Resolution within Cognitive Analytic Therapy are composed of acknowledgement, exploration, linking and explanation, negotiation, consensus, and understanding and assimilating warded off feelings, and further explanation, change to patterns/aims, and closure. Analysis was conducted with 107 enactments from 66 sessions, with four “good outcome” cases and “two poor” outcome cases (Daly et al., 2010). During the course of the study eighteen rupture resolution sequences were conducted, eleven of which resulted in two-thirds were resolved in “good sessions.” Good sessions are defined as completion of nine stages being addressed during therapeutic interactions with the participants. Of the sessions in which did not result in rupture resolutions, each occurred during “poor” sessions. Poor sessions were defined as therapeutic interactions not reaching each of the nine stages with the participants.

Of significant importance of the rupture resolution approach is the validation stage. Validation of personal thoughts, feelings and emotions represent core features of BPD in context of interpersonal problems. As stated by Daly et al. in their study (2010):

There was a significant relationship (p = .02) between number of model states observed and rupture resolution. Therapists included the early stages in almost all cases but there was a significant reduction in therapists’ use of the subsequent six stages (ie., negotiation through closure) in unresolved ruptures, irrespective of session type. (p. 279)

Three significant findings pertain to the utilization of rupture resolution when using cognitive models with BPD individuals, first, the number of model stages used correlate to successful rupture resolution. Second, the study’s qualitative and quantitative data demonstrate
successful use of rupture resolution to distinguish between client-rated good and poor sessions. Third, the number of model stages used is associated with clinician-rated treatment outcome, which is assessed after therapy ends (Bellino et al., 2010).

A study was designed utilizing a psychoanalytic approach for treating BPD. The treatment consisted of a multifaceted approach of weekly individual psychotherapy for 12 months weekly group analytic psychotherapy (one and half hours with 6-7 clients), and group-based psychoeducation for two months. Each of these treatments was based upon object relation’s theory in addition to core elements from attachment and mentalization theory. The treatment and subsequent study focused heavily on “relational aspects of borderline disorder and how the relational problems of these patients are linked to object relationship and failures in the ability to mentalize” (Jorgensen & Kjolbye, 2007, p. 169).

The methodology of the study included 19 patients over the course of two years in an outpatients setting. Each patient was diagnosed with BPD by an experienced psychiatrist. Data used for the study was based upon 15 months of the three modalities of Psychoanalytic Therapy; individual, group and group psychoeducation. The study used Beck Depression Inventory (BDI), Beck Anxiety Inventory (BAI), and the Symptom Check-List (SCL-90-R). Eight clients dropped out of the study, and therefore data was collected from eleven. Data was collected at “-90 through 45 days, 3 months: 46 though 135 days, 6 months: 136 through 230 days etc.” (Jorgensen & Kjolbye, 2007).

The results of this pilot study from data collection methods showed improvement in anxiety and depression symptoms and substantial improvement in general functioning. The mean BAI score went from 14.78 to 9.95, the BDI mean score went from 25.00 to 21.35, and SCL-90, GSI-score went from 1.43 to 0.89 from admission to 15 months with scores taken
every three months. Statistical analysis showed that all changes in self-reports were significant, but a distinction made by the authors is level of functioning was clinically significant whereas changes in depression and anxiety are considered to be non-significant. The study indicates that intensive outpatient treatment utilizing psychoanalytic foundations is beneficial for individuals with BPD based on 15 months of treatment with multiple modalities. It is a limitation of this study that it was conducted in an unstructured outpatient clinic, with limited supervision of practitioners. The unstructured format may explain a high drop out rate comparatively to other studies, which are inpatient, or in a hospital. This study illuminates a core feature of treatment with individuals with personality disorders, and specifically BPD, which is structured implementation of treatment. However, the study concludes that “borderline patients are unlikely to show substantial improvement” and therefore “It is reasonable to assume that the positive changes observed can be attributed to the treatment offered” (Jorgensen & Kjolbye, 2007, p. 178). Variations within cognitive therapy structures have also been utilized for treatment of BPD such as Mentalization Based Therapy (MBT) and Cognitive Analytic Therapy (CAT). The theoretical frameworks of MBT and CAT provide insight into the development of BPD, which provides guidance to treatment.

MBT and CAT effectiveness has been compared in the article “Psychotherapy for Borderline Personality Disorder: Mentalization Based Therapy and Cognitive Analytic Therapy Compare” by Bateman, Ryle, Fongay, and Kerr (2007). MBT utilizes pieces of concepts from other theories, most notably contingency theory, and attachment theory and seeks to link core concepts with neurophysiology. MBT has eliminated psychoanalytic concepts of emphasis upon “revealing unconscious meaning” (Bateman et al., 2007, p. 51). In essence, MBT is an integrative approach that has pulled together core ideas from multiple theories. CAT’s core
components are a reframing of psychoanalytic object relations to a cognitive behavioral approach. The integration of Reciprocal Role Procedure (RRP) seeks to address and modify object relations based upon the assumption that “a child’s experience is seen as more crucial than hypothesized universal unconscious conflicts” (Bateman et al., 2007, p. 51).

Bateman et al. (2007) explained that the underpinnings of MBT are Bowlby’s Attachment Theory. It is assumed by AT that the development of a person’s personality that “their emotional signals to be accurately or contingently mirrored by an attachment figure” (Bateman et al., 2007, p. 52). It is implied that inconsistent care giving provides potential disorganized attachment; potentially producing disorganized behaviors such as disassociation. Disassociation may be viewed as a fragmentation of the self, which is consistent with BPD personality traits. Disruption in personal achievement by psychological trauma such as sexual abuse may cause difficulty for an individual to identify mental states. If one cannot identify or articulate mental states due to actions of a primary caregiver an individual may perceive others as malevolent. Bateman et al. (2007) argued “The phenomenology of BPD is the consequence of this inhibition of mentalization, and the re-emergence of modes of experiencing internal reality that antedate the development of mentalization” (p. 52).

Bateman et al. (2007) argues from the perspective of CAT articulates “early development sees attachment security as a necessary but not sufficient condition for normal development” (p. 53). This concept is further explained by viewing attachment as a function far beyond just a provision of safety, but as a social being. CAT focuses on the context of interactions with other human beings, most importantly primary caregivers. If Reciprocal Role Procedures (RRP) are interrupted or disjointed, a child’s understanding and internalization of social roles is damaged. Early relationships between child and others “determine how others are
perceived and how subsequent interpersonal roles are enacted” (Bateman et al., 2007, p. 53).

MBT and CAT have practical applications such as mechanisms of change, identification of distorted cognitions and development of insight into behaviors. The use of homework provides ongoing monitoring of symptoms associated with RRP’s and introspection into dissociated states (Bateman et al., 2007). Bateman et al. (2007) asserts there are limitations to therapists identifying with MBT or CAT due to incompatibilities in the development of BPD.

Joel Paris explores the use of medications to BPD in his article “Pharmacological treatment for personality disorder.” The author’s utilized MEDLINE search from 1950 to 2010 to review articles related of prescribing medications to individuals with personality disorders, the vast majority of them concerned BPD, and therefore his review focuses on this specific disorder. Paris reviews the use of antidepressants, which only had a slightly improved affect over a placebo. Paris’ review of Tricyclics brought forth the concerns that clients with personality disorders prone to suicidal behaviors could easily overdose. The use of mono-amine oxidase inhibitors showed some improvement, specifically “two clinical trails of phenelzine have reported symptomatic improvement in BPD, but not a full remission of depressive symptoms. The medications Carbamazepine and Valproate have been studied and shown to reduce impulsivity in BPD patients, but has no conclusive indications for targeting symptoms of mood instability. Within the classification of antipsychotics the medication Olanzapine has suggestive evidence for its reduction in impulsivity and has been shown to be the most consistent within doing so. Paris states that none of the medications explored in his article provide full remission of symptoms unlike other mental illnesses. Paris explores the use of what he terms poly-pharmacy, which is the use several medications for specific symptoms at specific times throughout the course of BPD. As noted in this article “there has been no research on drug
combinations in BPD, and such practices make it even more likely that patients suffer from side effects” (Paris, 2011, p. 305). Paris’ article asserts that having a control within a study for BPD using medications is difficult, and therefore there is limited research for pharmacological treatment of BPD, the use of medications for BPD continues.

Schema Therapy (ST) has been developed and has evolved as theory that integrates core concept from cognitive-behavioral, attachment, psychodynamic and emotion-focused elements. Kellogg and Young (2006) argued that Schema Therapy is effective in treatment for BPD by identifying BPD individuals as “under the sway of five modes or aspects of the self” (p. 445) Treatment is provided by addressing four modes: limited reparenting, experiential imagery and dialogue work, cognitive restructuring and education, and behavior pattern breaking. Kellogg and Young (2006) argued that each of the four modes treated by interventions within three phases: bonding and emotional regulation, schema mode change and development of autonomy. Schema Therapy is influenced by a developmental theory and rests assertions on the development of the disorder. Kellogg and Young (2006) argue four family environmental situations and Young (2006) that may contribute to the development of BPD, which are the family environment is unsafe and unstable, depriving, harshly punitive and rejecting, and subjugating. Each of the four elements would typically be found in a family environment that is abusive and neglectful, in alternative terms, invalidating. This environment is argued to produce modes “of cruelty, rage, submission, and self-numbing” (Kellogg & Young, 2006, p. 447). Thus, if a clinician is able to understand a constantly fluctuating interplay of these modes, BPD behaviors have the potential to explain irrational behavior (Kellogg & Young, 2006). Due to the development of these modes and interplay between them, other modes that allow for healthy interaction are developed or used. The healthy adult role is explained as the mode in which
individuals are able to provide themselves with nurture, protection, self-setting personal limits and coping with dysfunction. It is as argues by Kellogg and Young (2006) as “what the BPD patient, for the most part, is missing” (p. 449)

The common conception of BPD is the individual is on consistent and near constant fear of other individuals abandoning them. It is based upon the understanding that with the exception of impulsivity and moodiness that the fear of abandonment is the single most significant factor in working with individuals with BPD. Authors Nysater and Nordahl in their article “Principles and Clinical Application of Schema Therapy with Borderline Personality Disorder” contend, “Feared or real abandonment can easily trigger emotional outbursts that tend to lead to provocations or disappointments” (Nysater & Nordahl, 2008, p. 249). Further the authors explore how past physical, sexual, and emotional trauma can add to the difficulty in BPD individuals developing and maintaining healthy relationships with others. Similar to the Adlerian conception of the lifestyle Schema Therapy also holds a view that individuals with BPD or any other personality disorder hold rigid and dysfunctional belief systems. These belief system are formed by perceptions, memories, and interactions with others starting from an early age. Schema Therapy utilizes the concept of Early Maladaptive Schema’s or EMS, which is defined as themes developed early in life that make up the individuals self-concept and conception of their environment. Schema Therapy seeks to address not specific EMS’s, but the fluctuating between modes by the individual with BPD. The four modes specifically stated for the BPD individual are 1) the abandoned child, 2) the angry and impulsive child, 3) the punitive parent, 4) the detached protector, and 5) the healthy adult. The focus or goal of Schema Therapy is helping the BPD individual identify and cope with the various schema modes, and this is accomplished through learning specific skills to control impulses.
While BPD individuals explore and expand upon various modes the therapist acts in an alternative fashion comparatively to other theoretical models, the therapist acts as the parent or healthy adult until the individuals are able to themselves. As Kellogg and Young (2006) explained:

The weakness of this mode in BPD patients is an important contributor to the turbulence in their life. One of the functions of the therapist is to take on the role of the healthy parent (within the limits of a therapy relationship). Schema therapy for BPD is thought to take at least 2 years, because the central goal is for the patients to begin to internalize the therapist as the healthy parents. In this way, patients can eventually do for themselves what the therapist is doing for them in the session. (p. 449)

Summary of Outpatient Therapy Models

Outpatient therapies of Interpersonal Psychotherapy, Pharmacotherapy, Rupture Resolution in Cognitive Analytic Therapy, Psychoanalytic, Mentalization Based, Cognitive Analytic and Schema Therapy provide a broad array of models used by clinicians. The research articles used for this literature review in relation to outpatient therapy models are oriented to the diagnosis, development and conceptualization of BPD. Studies are focused more on the etiology, course and behaviors or modes within BPD than client or clinician rated treatment of the disorder directly or maladaptive behaviors. The articles provide outpatient, presumably independently practicing clinician, with a variety of options.

The article by Bellino et al. (2010) provides suggestive evidence that Pharmacotherapy while aiding in effective treatment on its own of BPD is more effective as an addition to Interpersonal Psychotherapy. Rupture Resolution in Cognitive Analytic Therapy defines and delineates what a rupture consists of, which are common occurrences within therapy with BPD.
individuals. Further, it provides a structure in which therapists have the ability to be self aware and work within a context. The study of psychoanalytically oriented therapy provides significant evidence that treatment of BPD must be structured. Jorgensen and Kjolbye (2007) argued, “there is relatively little compelling evidence that individuals with personality disorders and low functioning can be successfully treated on an outpatients basis” (p. 177). MBT and CAT provide significant information related to the development and course of BPD, and imply a reorganizing of lost childhood experiences for BPD individuals. ST explores modes in which all human beings have the potential to operate. Kellogg and Young (2006) imply that due to childhood experiences BPD individuals do not have the ability to engage in the healthy adult mode. The healthy adult mode has features which BPD lack and therefore is unable to regulate their emotions, a core feature of BPD.

Each outpatient model explored within this writer’s literature review is developmental in nature except for Bellino et al. (2010), and therefore has limited statistical studies. They do however explore in greater detail a developmental model of BPD, and potentially an alternative view of treatment of BPD. A more accurate understanding of the development of BPD has a higher potential for effective treatment of the disorder.

**Research**

Research for this literature review was gathered through the Adler Graduate School’s library utilizing their access to online academic journals, and through the professional journal search engine EBSCO. This writer used a total of 30 sources, 25 of which are primary sources. The primary sources for this literature review primarily focused one of two areas, the first being the efficacy of DBT and alternative outpatient therapy models for BPD, and the second being background information needed for improved understanding of the diagnosis and course of
BPD. The secondary sources used in this literature review were used to develop core Adlerian concepts of lifestyle, neurotic tendencies, diagnosis, and safeguarding behaviors. Throughout this literature review this writer has used personal experiences to assist in developing a practical understanding or application of concepts and techniques with the BPD population. This writer was limited to the search engine of EBSCO, and the available resources at Adler Graduate School.

**Summary**

The diagnosis of BPD has distinctly unique and difficult challenges for the practicing therapist. Often there are disruptions in the therapy process, early termination of therapy, therapist burnout, and difficulty delineating between effective interventions or therapy models. This literature review is designed to explore the components of various treatment models for BPD comparatively to DBT. The research provided within this review attempts to articulate the efficacy of DBT versus alternative outpatient models. Results of this literature review are shown through an exploration of research, how and why treatments are applied, and the development of the treatment.

DBT as designed by Marsha Linehan has been shown to be more effective in the treatment of BPD than alternative outpatient treatment models due to its effectiveness of treating severe maladaptive behaviors. DBT has been shown throughout this review to reduce suicidal and parasuicidal behaviors through its structured format and conceptualized treatment. Andion et al. (2012) found that emergency room visits and self-harming behaviors dropped to 69.2% and a 75% reduction in self-harm behaviors. The authors summarize significant findings of this study; “Our results are similar to those observed in previous DBT studies that have
analyzed the reductions in suicide attempts, self-harm behaviors, and the number of visits to emergency departments” (Andion et al., 2012, p. 248).

Authors Davenport, Bore, and Campbell (2010) present a review of the specific mechanisms of change as an individual undergoes DBT by examining self-regulation and self-control in pre and post DBT for BPD individuals. Their study utilized the five-factor-model to assess for personality trait levels.

DBT is an evidence-based therapy with clear efficacious impact but this is measured through behavioral markers such as reduction in self-harm and suicidal thoughts. Our research has served as a beginning point for future research into this area because it has found significant relationships between aspects of both personality and self-control that appear to have altered as a result of therapy (Davenport, Bore, and Campbell, 2010, p. 62).

In Robins et al. (2010) the authors explore the evidence-based treatment of DBT and state “DBT has now been empirically evaluated in at least 10 randomized clinical trails. Overall, the clinical outcome data support the efficacy of DBT as a treatment for women with BPD. Four RCT’s have found DBT to have superior efficacy when compared with treatment as usual for women with BPD and suicidal or other self-injurious behavior.” The authors further state that DBT has been proven more effective in treatment of BPD in terms of “reducing the frequency and medical severity of suicide attempts, self-injurious behavior, frequency and medical duration of psychiatric hospitalizations, and client anger, as well as in increasing treatment compliance and social adjustment” (Robins et al., 2010, p. 72).

This writer believes that DBT’s success is due to its structure, which is designed to address Linehan’s conceptualization of BPD. Linehan et al. (2009) state that “One probable
pathway is identified that leads to borderline personality disorder; it begins with early vulnerability, expressed initially as impulsivity and followed by heightened emotional sensitivity. These vulnerabilities are potentiated across development by environmental risks factors that give rise to more extreme emotional, behavioral, and cognitive dysregulation.” DBT utilizes the most comprehensive conceptualization of the development of BPD. Each of the outpatient therapy models provide theories as to the development, but lack statistical analysis needed to solidify them as equally efficacious as DBT.

The three foundations of DBT are the invalidating environment, behavior theory, and dialectical theory provide the framework for change in BPD that is significantly more robust and proven in studies that alternative outpatient treatments do not. This writer has a bias that understanding the etiology of the symptoms within a disorder ultimately provides the practicing clinician with a more insight and ability to treat it as explained by Robins et al.

Over time, as the individual’s behavior becomes more extreme, in attempts to regulate emotion or to communicate, he or she is increasingly likely to experience invalidation from the environment (often including the mental health system), and in response the sensitive individual is likely to feel even more emotionally vulnerable and react more intensely, thereby generating further invalidation. Thus, in this transactional model the individual and those in his or her interpersonal environment continuously influence one another. The individual comes to experience frequent and pervasive emotion dysregulation and has poor emotion regulation skills, often relying on ultimately maladaptive coping behaviors. (Robins, Rosenthal, & Cuper, 2010, p. 51)

Robins et al. provide the most convincing explanation of the extreme nature of symptoms that BPD client’s exhibit, which allows clinicians to gain insight into their purpose.
A common theme within Adlerian Psychology is that all behaviors have a purpose. It is this writer’s bias that the more insight and knowledge a clinician has, the more effective the treatment provided is. Additionally, clinicians having a strong sense of the purpose in client behaviors, the more likely clients are to feel a therapeutic connection with their therapist.

The foundation of DBT has the understanding that parasuicidal and suicidal behaviors are common and therefore has a protocol built in so that clients may call in between sessions when experiencing suicidal feelings. The structured format allows not only for a progression through treatment for client, but also clinicians. The structure removes much of the potential feelings of ambiguity that traditional psychotherapy may contain, thus allowing for therapist and client to focus on mutual goals. Throughout the model of DBT there are behavioral skills that clients are taught within a group setting. The group setting allows for the potential of clients gaining greater insight into how their behavior may impact others. Skills training also coincide with progression through therapy, and may be reflected or reinforced in individual therapy sessions. DBT is the only treatment for BPD, which includes a model for the wellbeing of the therapist through routine case, consults to reduce therapist burnout. The comprehensiveness of the DBT model allows for increased ability for case formulations, thus allowing for greater insight from the therapist in their work with clients.

**Final Summary and Significance**

This writer’s literature review sought to explore the following: Marsha Linehan’s Dialectical Behavior Therapy structured model will have a more significant impact and conceptualization, and treatment than alternative outpatient treatment models for Borderline Personality Disorder. DBT can be best understood and viewed as both a theory and a structured therapy model for patient and therapist alike. Rizvi et al. (2012) encapsulates DBT as:
Treatment, the incorporation and integration of four domains (biological, social-environmental, spiritual, and behavioral) in a single treatment in a way that appeals to those of different backgrounds, the synthesis of acceptance and change strategies as well as practical and theoretically sophisticated strategies, and specific structures that address the therapists’ own need for support while treating a difficult population. (p. 1)

The influence of DBT is well known anecdotally by independently practicing clinicians as well as academically through a significant amount of research studies since nineteen-ninety-three. This writer asserts that DBT’s success is not due to a singular reason, but multiple factors. These factors are built into DBT in its foundational principles of biosocial theory of the development of BPD behaviors, behavioral theory, and dialectical philosophy” (Rizvi et al., 2012, p. 2). Subcategories within these principles provide a further explanation into its pragmatic use with BPD patients; the one used most notably is the invalidating environment. An invalidating environment for the purposes of this literature review is defined as “emotions may not be validated when the expression of private emotional experiences is not tolerated by important people in the individual’s environment” (Rizvi et al., 2012, p. 2). The concept of an invalidating environment is supported by Bateman et al. (2007), “a child’s experience is seen as more crucial than hypothesized universal unconscious conflicts” (p. 52). Biosocial theory is predicated upon the assumption that invalidating environments play a key factor in the development of BPD.

Authors Swales, Heard, & Williams (2008) in their article “Linehan’s Dialectical Behavior Therapy (DBT) for borderline personality disorder: Overview and adaptation” explore the efficacy of DBT based on the “number of lifetime Parasuicide episodes, number of lifetime admissions to the hospital, age and prognosis” (p. 18). The study was conducted using two
groups; the first group of BPD clients who received weekly individual psychotherapy and group skills for one year, and the second group receiving treatment as usual in outpatient psychotherapy settings. Each of the participants was assessed at pre-treatment, 4, 8, 12, 18, and 24 months. The results of the study provide convincing evidence that DBT is a significantly more effective treatment for BPD than alternative outpatient models of psychotherapy. Swale et al. (2008) states;

Over the course of the treatment year, DBT client reported engaging in significantly fewer parasuicidal episodes and less medically severe episodes when compared to control clients. DBT clients were also more likely to remain in therapy. Among those clients who started treatment with a new therapist at the beginning of the project, the 1-year attrition rate in the DBT condition was 16.7% compared to a rate of 50% in the control condition. DBT clients also had significantly fewer psychiatric in-patient days compared to the control clients (DBT=8.46 days/year; TAU=38.86 days/year) (p. 19).

Len Sperry explores numerous case formulations, assessment, and treatment options for BPD as well as brief summaries of empirical evidence related to each treatment option in his book “Diagnosis and Treatment of DSM-4-TR Personality Disorders” (2003). Sperry states; “Early studies reported the efficacy of this approach (DBT). When compared to patients receiving treatment as usual, those in DBT had a significant reduction in suicidal behavior and hospitalizations and remained in therapy longer- that is, attrition rates were only 16.7 percent for those receiving DBT while over 50 percent for others. Evidence for the efficacy of dialectical behavior therapy continues to mount. This approach has now been supported by several randomly controlled studies. Furthermore, dialectical behavior therapy has been
adjudged superior to the typical supportive, intermittent treatment that many borderline individuals receive in their community. (Sperry, 2003, p. 102)

Sperry’s arguments summarize the effectiveness of DBT to provide effective treatment for parasuicidal, suicidal behaviors, and deliberate self-harm through skills training, group therapy, individual therapy, and phone contact when needed. Sperry further points out that DBT is an effective treatment for both lower and higher functioning individuals due the design of DBT, and the ability of the clinician to tailor treatment while remaining within the structure Linehan designed.

Rizvi et al. (2012) adds additional evidence in support of DBT as more effective than alternative outpatient psychotherapy models for maladaptive behaviors. Authors state that in the;

12 months of DBT to treatment as usual (TAU) and found a greater reduction in the frequency and medical severity of self-injurious behaviors, the frequency and length of inpatient hospitalization, and treatment drop out, as well as some evidence for reduction in anger, depression, hopelessness, suicidal ideation, NSSI, and alcohol abuse (Rizvi, Steffel, & Carson-Wong, 2012, p. 3).

One of the limitations of this literature review is the lack of data exploring the prevalence of a more detailed explanation of an invalidating environment of individuals with BPD. While no numerical data exists the article “Dialectical Behavior Therapy as a Treatment for Deliberate Self-Harm: Case Studies from a High Security Psychiatric Hospital Population” explored personal experiences of individuals with BPD. In general, Low et al. (2001) explained the treatment of Ms. A by explaining by the use of a behavior chain. They stated, “Ms. A attended all sessions, which took place on the ward. During the first 4 months, treatment
focused on a behavioral chain analysis of each incident of deliberate self-harming behaviour” (Low et al., 2001, p. 291). Ms. A’s explanation is limited by not including group DBT sessions, but provides an example of implementing DBT effectively in a unique setting with a significantly impaired client.

BPD is characterized by behaviors such as suicidal, parasuicidal and self-harming behaviors, which therapy, regardless of orientation must address for effective therapy to take place. This writer asserts that to effectively answer whether DBT or outpatient psychotherapy models are more effective, the answer is in addressing core elements of the disorder. The core concern of this literature review is the effective treatment of suicidal, parasuicidal and self-harming behaviors. From the research articles used in this literature review, DBT provides a more efficacious treatment for core BPD behaviors. Further, articles concerning outpatient models provide therapists fundamental theoretical underpinnings of BPD, which at time is more comprehensive than DBT, but lacks empirical evidence of the treatment of the disorder.

Outpatient psychotherapies reviewed in this literature review do not facilitate a fully holistic treatment of BPD, and therefore. It is of note that this writer is biased to Individual Psychology, and is influenced by the degree a treatment provides patients with holistic care.

The attitude of the therapist when treating BPD is a significant but unstudied factor due to its implications for the effective treatment of BPD. Authors Wenzel, Jeglic, Levy-Mack, Beck, and Brown contend in their article “Treatment Attitude and Therapy Outcome in Patients With Borderline Personality Disorder” that:

Results from this study suggest that attitudes toward treatment are associated with various aspects of therapy outcome in patients with BPD. Specifically, more positive attitudes toward talking with a therapist about one’s problems were associated with less

This writer includes a brief discussion regarding the attitude of the client and therapist when working with BPD due to practical implications. While there is no specific supporting evidence this writer asserts that the relationship between therapist and client must be that of mutual trust and respect.

Each of the articles exploring outpatient models used in this literature review provides new foundations or alterations on previous theories to provide structured treatment for BPD clients. The article “Schema Therapy for Borderline Personality Disorder” provides the most well developed structure in which to treat maladaptive behaviors. Kellogg and Young (2006) delineate a human being's life into specific and separate schemas, all of which include core features for useful social development. Schema Therapy attempts to rebuild what is presumed to be lost during the childhood of an individual with BPD. Since ST is heavily based upon a developmental model, it implies a rebuilding of some schemas while creating others. It appears to be a comprehensive theory, which treats an individual with BPD holistically. Schema Therapy like Interpersonal Psychotherapy, Pharmacotherapy, Rupture Resolution in Cognitive Analytic Therapy, Psychoanalytic, and Mentalization Based does well in assisting independent practicing clinicians a theoretical foundation for work with BPD, but does not provide holistic practical application. Several of the outpatient models do not specifically address suicidal, parasuicidal and self-harming behaviors. DBT however, appears too more effectively utilize core components in the diagnosis of BPD from the Diagnostic and Statistical Manual of Mental Disorders than do existing outpatient models. Thus, DBT follows a comprehensive course of
BPD’s diagnosis; course and treatment while striving to holistically take into account both the patient and therapist.

Jorgensen and Kjolbye (2007) argued, “there is relatively little compelling evidence that individuals with personality disorders and low functioning can be successfully treated on an outpatients basis” (p. 177). Each of the outpatient therapies explored provided limited it any data containing its effectiveness, but rather explore their unique theory of how it is beneficial. Aspects of each outpatient model explored in this literature review illustrate engaging and thought provoking new conceptualizations regarding the treatment of BPD.

All articles in this literature review for outpatient models assume or imply that clinicians will be practicing independently, which may or may not be true. DBT specifically is structured so patients and clinicians will be as successful as possible. None of the articles articulate the affect on clinicians while treating BPD. Each does however imply agreement in the difficulty of treating the disorder, which implies practical affects upon the clinician. The most common issue facing clinicians is burnout, which appears to be derived from the intensity of the disorder and as a product the extreme nature of issues clients and therapists are working on. This writer’s experience in working with BPD is the severity of the behaviors clients have engaged in for attention and to pull others closer to them due to the fear of abandonment. This writer has been working with a 46-year-old female diagnosed with BPD and OCD. During the course of individual therapy with this writer she has engaged in suicidal threats, gestures, and been hospitalized several times. Each suicidal gesture or behavior appears to have occurred when she has substantial gains or setbacks, and therefore threatening her sense of well-being. From an Adlerian perspective her lifestyle can be seen behavioral of being an incapable person. Her mistaken beliefs about the world are that she should not have to take care of herself because she
believes herself to be incapable. From a first hand perspective self-harming behaviors, suicidal gestures, and suicidal threats significantly impede progress. Additionally, these behaviors are discouraging for the client and this writer. The behaviors act as sideshows that are defensive mechanisms to avoid painful experiences or feelings.

A majority of practicing clinicians in outpatient settings will encounter individuals with BPD, whether they are diagnosing, treating, or providing any type of mental health service. The prevalence rates the general population with BPD are 6% and of outpatient psychiatric services at 8-11%, inpatient at 14-20%, and forensic samples at 60-80%. Due to the course and severity of the disorder up to 10% of the BPD population will complete suicide, a basic understanding of BPD will not suffice. It is critical that practicing clinicians are provided the most robust, holistic, and current knowledge regarding BPD that exists. Without a full conceptualization regarding BPD from diagnosis through the course of treatment it is extremely unlikely that effective long-term treatment will occur on a meaningful large-scale level. Currently DBT is the most comprehensive and structured tool clinicians have available for a structured treatment model a difficult and vulnerable population of individuals.

**Conclusion**

This writer concludes that DBT is currently the most supported model for working with BPD and subsequent maladaptive behaviors when compared to alternative outpatient therapy models. Studies indicate that DBT offers the most robust explanation of the etiology of BPD, treatment of symptoms, results, and support of the therapists working with BPD clients. This writer asserts that DBT due to its design and incorporation of behavior theory is the most effective treatment of BPD, specifically in the area of changing self-harming behaviors. Studies of DBT have been replicated to show sustained behavioral changes in BPD clients, however
there is little or no mention about individuals of quality of life. This writer has learned through the course of this literature review that any successful treatment of BPD must include behavioral changes of self-harming behaviors, but also a change in how individuals with BPD engage in relationships with others. This writer asserts that a combination of DBT as designed and implemented by Marsha Linehan, and Adlerian Psychology including a lifestyle assessment over the course of one year would provide the most effective treatment of BPD. The combination of DBT as an evidence-based practice that focuses on skills combined with an insight-oriented model of psychotherapy could more effectively treat BPD. Current practicing clinician’s benefit from having an understanding of core components and the theoretical model used to develop DBT, which can be incorporated into practice with BPD clients.

There are practical issues facing clinicians such as financial constraints, it is unlikely that every therapist or agency will be able to provide DBT as designed by Marsha Linehan. However individuals with BPD will continue to receive outpatient psychotherapy, and therefore information within this literature review may provide basic information regarding BPD and effective treatment. It is this writer’s opinion that at current moment DBT is the most useful therapy for BPD. There is simply not enough information regarding longitudinal studies on alternative outpatient therapy models to accurately state that they would or would not be effective in the treatment of BPD. Each of the outpatient models explored in this review has useful insights into conceptualizing and treating BPD, but has not provided sufficient evidence to argue having a more significant impact on the maladaptive behaviors of BPD clients.

**Recommendations for Future Research**

This writer recommends that future research be conducted regarding the effectiveness of outpatient models of psychotherapy for BPD for a more accurate comparison to DBT.
Throughout gathering research for this literature review this writer was surprised that information regarding the effectiveness of various psychotherapies did not exist when used with BPD. Future studies conducted on Interpersonal Psychotherapy, Rupture Resolution in Cognitive Analytic Therapy, Psychoanalytical, Mentalization Based Therapy, Pharmacology, Cognitive Analytic and Schema Therapy will allow practicing clinician’s practical and pragmatic options for effective treatment of a difficult disorder. Additionally this writer recommends that a study that would provide a cost benefit analysis of DBT. In this writer’s direct experience BPD clients often utilize several mental health and medical services, which can burden the system financially. A study that can offer the financial benefits of DBT could potentially influence or garner additional financial resources to provide the service.
IMPACT OF DBT VERSUS ALTERNATIVE OUTPATIENT THERAPIES

References:


