Chapter 1

# Introduction

This book describes a different way to treat borderline personality disorder (BPD). Rather than using one of the manualized treatments developed in recent years, a trans-theoretical approach is proposed that combines principles, strategies, and interventions from all effective treatments. Reluctantly, I decided that a name was needed for this approach and decided on integrated modular treatment (IMT). However, my intention is not to develop yet another therapy described by a three-letter acronym but rather to show how therapists can make use of effective methods from all therapies without adopting either the total treatment package or the underlying theory.

This is not how BPD is currently treated. Treatment is usually based on one or more of the following specialized treatments shown to be effective in randomized controlled trials: dialectical behaviour therapy (DBT), transference-focused therapy (TFT), schema-focused therapy (SFT), mentalizing-based therapy (MBT), cognitive-behavioural therapy (CBT), cognitive-analytic therapy (CAT), and systems training for emotional predictability and problem-solving (STEPPS).[1] Since these treatments do not differ in effectiveness, however, there are no scientific grounds for selecting one approach over another. Nor do they produce better outcomes than good clinical care or supportive therapy. Hence, it may be more effective to combine the effective ingredients of all therapies rather than choose among them.

There are other reasons to pursue integration. Current treatments are not comprehensive: most are based on theories that explain BPD largely in terms of a single impairment, which then becomes the main focus of therapy with other impairments receiving less attention. Thus, DBT considers emotional dysregulation to be the primary problem. MBT assumes that it is impaired mentalizing (difficulty understanding the mental states of self and others). SFT focuses primarily on early maladaptive schemas – beliefs that originated in dysfunctional relationships with significant others during early development. Finally, TFT assumes that problems are largely due to disturbances in the structure of personality. Each explanation has merit: BPD does indeed involve emotional dysregulation, dysfunctional cognitions, impaired mentalizing, and structural problems with personality, but patients do not have just one of these impairments, they have all of them. Hence, a trans-theoretical approach makes more sense.

Current therapies are also limited by the use of "one method fits all patients" approach that neglects the enormous heterogeneity of BPD: patients differ substantially in severity, co-occurring disorders, and coexisting personality characteristics, and these differences impact treatment. This suggests the need for a more patient-focused approach with treatment tailored to needs and psychopathology of individual patients.

This chapter provides a broad overview of an integrated approach. It begins by describing briefly the main features of BPD followed by a discussion of the implications of treatment outcome studies. Finally, it provides an overview of IMT to orientate the reader to the approach.

## 1.1 Borderline Personality Disorder

BPD occurs in 0.5 to 3.9 per cent (median 1.4 per cent) of the population.[2] Estimates vary because of differences in samples and in definition and assessment methods. Also diagnostic thresholds – the DSM-5 requires the presence of five out of nine criteria – are arbitrary and a different threshold (four or six criteria) would lead to different prevalence rates. Nevertheless, it is obviously a common disorder.

Individuals with BPD tend to have significant health and social problems leading to heavy demands on social and health care services. Interestingly, health problems are not confined to mental health difficulties: BPD is associated with a higher incidence of medical conditions that do not appear to be directly related to the disorder. The condition is also associated with increased mortality. Some of this increase is due to suicide – approximately 9 per cent complete suicide.[3] However, suicide does not totally explain increased mortality – other factors contribute as well, including alcohol and substance misuse.

### 1.1.1 Major Characteristics

Throughout this book, BPD is conceptualized as a pervasive pattern of instability and dysregulation involving unstable emotions, unstable and conflicted relationships, unstable sense of self or identity, unstable cognitive processes, and behavioural instability that is assumed to result from the interaction of genetic predispositions and multiple environmental influences. The instability is so pervasive and consistent that patients with the disorder have been described as "stably unstable."[4] However, instability is not the only pervasive feature. The disorder is also characterized by intense conflict and equally intense rigidity. The conflict is both external in the form of conflicted relationships and internal in the sense that these patients are often at war with themselves as they struggle with inconsistent feelings and to suppress painful feelings and memories and deny important aspects of their personality and experience. They are also rigid in thought and action. Events are interpreted in relatively fixed ways and it is difficult to change perspective and see things from alternative viewpoints. Their modes of action are also rigid: they persistently respond to situations in the same way despite these responses being unproductive. The features of BPD are described in detail in Chapter 3. It should be noted, however, that the disorder is described a little differently here than in DSM-5 largely because the DSM description is based primarily on committee decisions whereas here greater emphasis is given to research findings.[5]

Emotional dysregulation is a central impairment that influences how other features are expressed. Life for people with BPD is a roller coaster of unstable, intense, and chaotic emotions. Crises are common and typically involve a collage of anxiety, fearfulness, threat, despair, sadness, anger, rage, and shame. Interpersonal problems largely revolve around conflict between strong attachment and dependency needs and fear of abandonment and rejection. This creates unstable relationships because intense neediness leads to an urgent need for contact with significant others when stressed, which then activates fear of rejection. Instability in self or identity is shown by a poorly developed and an

unstable sense of self. Many individuals also show a tendency for their thinking to become disorganized when stressed, which may progress to suspiciousness and brief stress-related psychotic episodes. Behavioural instability typically occurs in the context of emotional crises and usually involves deliberate self-harm, suicidality, and sometimes regressive and dissociative behaviours.

### 1.1.2 Heterogeneity

Although diagnostic systems such as DSM-5 treat all individuals who meet diagnostic guidelines as the same, patients differ extensively in ways that affect outcome and treatment planning. Differences in severity of personality pathology, for example, are more important than the type of disorder in predicting outcome.[6] Severity also influences treatment planning: in general, increasing severity suggests less intense treatment, more modest goals, and greater reliance on supportive methods.

The features of BPD do not occur in isolation but rather in the context of a variety of other personality dispositions that influence treatment both positively and negatively. The co-occurrence of compulsivity, for example, is usually beneficial because it leads to greater diligence in pursuing treatment goals. Traits such as sensation seeking and recklessness, on the other hand, hinder treatment because they involve intolerance of boredom and a craving for excitement that may contribute to interpersonal crises and various maladaptive behaviours. In contrast, social apprehensiveness may hinder the formation of an effective treatment relationship. This suggests that although contemporary therapies neglect heterogeneity, it has important consequences that need to be taken into account when planning and implementing treatment.

## 1.2 Treatment Outcome

A major achievement in the study of BPD in recent years is the accumulation of evidence that treatment is effective and that the magnitude of outcome change compares favourably with that for other mental disorders. This is a remarkable achievement given the therapeutic nihilism that existed previously.

### 1.2.1 Results of Outcome Studies

Evidence of the effectiveness of specific therapies is generally taken to imply that evidence-based treatment should use one or more of these therapies. Initially, the idea seemed reasonable because these treatments are more effective than treatment as usual. However, recent research points to a different conclusion for three reasons. First, these therapies do not differ significantly in outcome.[7] One study suggested that SFT is more effective than TFT. However, differences in outcome were small and largely offset by concerns that the quality of therapy was not comparable for the two treatments.[8]

Second, the specialized therapies do not produce better outcomes than good clinical care designed specifically for BPD. Thus far, only DBT, MBT, and CAT[9] have been compared to general care but there is no reason to assume the other specialized therapies would fare better. Also, the fact that these studies involved different therapies and were conducted by different investigators in different countries (Canada, England, and Australia) lends confidence to the robustness of the findings.

Third, the specialized therapies are not better than supportive therapy. One study compared short-term CBT with short-term Rogerian supportive therapy.[10] Although the authors interpreted their findings as indicating that cognitive therapy was more effective, differences were small and unlikely to be clinically significant. More importantly, outcome was poor for both therapies, suggesting that short-term therapy lasting a dozen or so sessions may be unhelpful in treating this disorder. A longer-term study comparing nearly two years of MBT with psychodynamic supportive therapy found few differences[11] despite that fact that the supportive therapy group received only about one-third the amount to therapy as the MBT group. The results are consistent with an earlier study showing that the long-term supportive therapy was as effective as more intensive TFT and DBT.[12]

### 1.2.2 Implications of Outcome Studies

Outcome studies clearly show that BPD can be treated effectively without using a specialized therapy. They also support an integrated approach: since all effective therapies incorporate treatment methods that work, a more rational strategy is to combine the effective components of all therapies rather than use a single therapy and thereby fail to use effective components of other methods. Integration is particularly pertinent given the limited focus of most specialized therapies: although individually none of the specialized therapies address all features of BPD, when taken together they cover most impairments. This has prompted suggestions that combinations of these therapies should be used – common suggestions are DBT and MBT, and DBT and TFT. However, this is a cumbersome and expensive option. It would be simpler and less confusing to select interventions that work from all approaches without trying to combine the different theories and concepts on which these therapies are based.[13]

The rationale for trans-theoretical treatment is further strengthened by evidence that similar outcome across treatments arises from change mechanisms common to all effective therapies. Evaluations of these mechanisms[14] point to the importance of such factors as a structured approach, a collaborative therapeutic relationship, an empathic and validating stance, and a consistent treatment process that facilitates motivation for change and encourages self-reflection. These are the kinds of factors emphasized in treatments based on good clinical care that were used to evaluate the effectiveness of the specialized therapies. Since these general factors account for most of outcome change, it seems most appropriate to organize evidence-based treatment around generic mechanisms.

Nevertheless, each specialized therapy contains interventions specific to that approach that probably contribute to their effectiveness. We cannot be sure because current studies do not provide information on the mechanisms responsible for positive outcomes. However, the need to use a comprehensive set of interventions that address all components of BPD suggests that IMT should also include an eclectic array of specific treatment methods.

## 1.3 What Is Integrated Modular Treatment?

IMT is a patient-focused, evidence-based approach to treating BPD (and other personality disorders) that uses a broad array of treatment principles and methods selected to meet the needs and problems of the individual. The term “integration” is widely used: proponents of

most therapies commonly claim that their approach is integrated even though it relies on a limited conceptual model. When used in this way, the term usually means that the therapy in question also uses interventions used by other treatments. In practice, most experienced therapists are integrative in this sense: they use interventions from various therapies that they have found useful even though they primarily subscribe to a particular school. IMT simply takes what expert therapists do a step further by using an eclectic combination of interventions selected on the basis of effectiveness and relevance for treating a given problem.

However, integration in IMT goes beyond adopting a trans-theoretical approach. Integration is also a treatment goal. BPD involves not only unstable emotions and relationships but also difficulty integrating experiences, thoughts, feelings, and actions and constructing a coherent sense of self. Hence, a central treatment task is to foster more integrated and coherent personality functioning.

The second term warranting explanation is "modular." This refers to the fact that treatment uses of an array of modules, each consisting of a set of inter-related strategies and interventions that seek to establish a particular treatment process (e.g., the treatment alliance) or target a specific impairment (e.g., unstable emotions). Based on the analyses of outcome studies, IMT uses two kinds of intervention modules: (i) general intervention modules that implement common change principles and (ii) specific intervention modules based on strategies and interventions selected from all treatments to treat specific impairments. This modular structure permits individualized therapy.

## 1.4 The Structure of Integrated Modular Treatment

The evidence indicates that treatment is most effective when based on a clearly defined model that specifies how therapy is organized and delivered.[15] This principle led to the development of two conceptual frameworks for IMT that describe the nature of BPD and the structure and process of treatment, respectively.

### 1.4.1 Framework for Describing Borderline Personality Disorder

The framework for understanding BPD, described in detail in Chapters 2–4 (see Box 1.1), is used to organize clinical information, plan treatment, and select interventions.[16] It is also intended to provide a framework for teaching patients about their disorder. Patients are often puzzled about why they are so upset, which adds to their distress and makes psychoeducation a necessary part of treatment.

The framework has three components. The first is based on the idea that personality is a complex system with multiple interacting components: traits, regulation and modulation mechanisms that control the expression of emotions and impulses, interpersonal structures, and self/identity. BPD affects all parts of the system. This idea is used to organize the multiple features of BPD into four domains of problems and impairments (see Chapter 2):

1. Symptoms: anxiety, fearfulness, emotional distress, rapid mood changes, self-harming behaviour, quasi-psychotic symptoms, dissociative behaviour
2. Regulation: impaired emotional control, tendency to act with a sense of urgency leading to self-harming behaviour

**BOX 1.1 The Structure of Integrated Modular Treatment**

**I. Framework for Describing Borderline Personality Disorder**

1. Personality as a complex system involving the trait, regulation and modulation, interpersonal, and self subsystems that give rise to four domains of impairment:
   a. Symptoms
   b. Regulation and modulation
   c. Interpersonal
   d. Self
2. Two-component structure:
   a. Core features common to all personality disorders:
      i. Interpersonal problems:
         - Inability to establish lasting intimate attachment relationships
      ii. Self problems:
         - Poorly developed sense of self
         - Unstable and fragmented self system
   b. Emotional dependency constellation of traits:
      i. Emotional traits:
         - Anxiousness
         - Emotional lability
      ii. Interpersonal traits:
         - Insecure attachment
         - Submissive dependency
         - Need for approval
      iii. Cognitive traits:
         - Cognitive dysregulation
3. Origins and development:
   a. Biological:
      i. Genetic predispositions
      ii. Other biological factors
   b. Psychosocial: clinically important factors
      i. Attachment problems
      ii. Invalidating environments
4. Clinical consequences of aetiological and developmental factors:
   a) Impaired regulation and modulation mechanisms
   b) Maladaptive schemas
   c) Maladaptive cognitive processes
   d) Core interpersonal conflict
   e) Distress without resolution
   f) Self system problems
   g) Conflict and functional incoherence

3. Interpersonal: attachment insecurity, submissive-dependent behaviours, conflicted and unstable relationships; maladaptive interpersonal relationships; maladaptive interpersonal beliefs
4. Self-Identity: boundary problems, poorly developed sense of self, unstable self and identity structure, maladaptive self-narrative, maladaptive self-schemas (e.g., "I am unlovable"), and problems with self-directedness.

Domains organize a patient's diverse impairments in a way that facilitates treatment planning and delivery. In general, each domain is treated with a different set of specific intervention modules. For example, symptoms may be treated with medication, and specific cognitive interventions and problems in the regulation domain are best treated with cognitive-behavioural modules that enhance skills in self-regulating emotions such as emotion recognition, distress tolerance, and attention control.

The second component of the framework is based on the idea that any personality disorder is best understood for diagnostic purposes as having two components: (i) *core features* common to all forms of personality disorder and (ii) a *constellation of traits* that differentiates a given disorder such as borderline from other personality disorders (see Chapter 3). This distinction reflects a current trend in the diagnostic classification to distinguish the features of general personality disorder from the traits that differentiate the various kinds of disorder. The features common to all personality disorders are chronic interpersonal dysfunction and an impaired sense of self and identity. With BPD, these core features are expressed as difficulty in establishing lasting intimate, attachment relationships and problems establishing a stable and coherent sense of self or identity.

Three kinds of traits define BPD: (i) emotional traits such as emotional lability and anxiousness, which give rise to unstable emotions and moods; (ii) interpersonal traits such as insecure attachment, submissiveness, and need for approval/fear of disapproval, which give rise to the conflict between neediness and fear of abandonment and rejection; and (iii) cognitive dysregulation – the tendency for thinking to become disorganized when stressed, which may progress to quasi-psychotic symptoms and dissociation. Interaction among these traits gives rise to the various kinds of instability described earlier.

The third component of the framework is a description of the origins and development of BPD and their implications for treatment (Chapter 4). Finally, an understanding of the lasting effects of adversity is used to define major impairments that are likely to be encountered in treatment and some of the major treatment strategies of IMT.

## 1.4.2 Framework for Organizing Treatment

IMT has two main components: (i) intervention modules and (ii) a stage model of how personality pathology changes during therapy (see Box 1.2). As noted earlier, intervention modules consist of *general treatment modules* based on change mechanisms common to all effective therapies and *specific treatment modules* consisting of interventions drawn from the various specialized therapies that target specific problems and impairments. The distinction between general and specific modules is important. General modules form the basic structure of treatment: they are used with all patients throughout treatment whereas specific modules vary according to the needs of individual patients and the problems that are the focus of therapeutic effort at any given moment.

This distinction implies a hierarchy of interventions. Priority is given to interventions needed to ensure safety of the patient and others.[17] Once safety is assured, general treatment

**BOX 1.2 The Structure of Integrated Modular Treatment**

**II. Framework for Organizing Treatment**

1. Treatment modules:
   a. General treatment modules:
      i. Structure: establish a structured treatment process
      ii. Relationship: build a collaborative working relationship
      iii. Consistency: maintain a consistent treatment process
      iv. Validation: establish a validating treatment process
      v. Self-reflection: increase self-knowledge and self-reflection
      vi. Motivation: build and maintain a commitment to change
   b. Specific modules:
      i. Crisis modules
      ii. Regulation and modulation modules
      iii. Interpersonal modules
      iv. Self modules
2. Phases of change:
   a. Safety: primary focus on the symptom domain
   b. Containment: primary focus on the symptom domain
   c. Regulation and modulation: primary focus on the symptom and regulation and modulation domain
   d. Exploration and change: primary focus on the interpersonal domain
   e. Integration and synthesis: primary focus on the self and identify domain and on building a satisfying life

methods are used to engage the patient in therapy, build an effective alliance, and establish conditions for change. When these conditions are met, specific interventions are used as needed to treat the problem at hand. This is an important practice point: specific interventions are only used when there is a good treatment relationship and a motivated patient. The only exceptions are when action is needed to ensure safety and when medication is indicated to address an immediate problem.

The second component of the treatment framework, the *phases of change model*, proposes that treatment progresses though five phases: (i) safety, (ii) containment, (iii) regulation and modulation, (iv) exploration and change, and (v) integration and synthesis. Each phase addresses a different domain of borderline pathology. Hence each phase involves the use of a different set of specific intervention modules.

#### 1.4.2.1 General Treatment Modules

Generic strategies and interventions are organized into six general treatment modules: (i) structure, (ii) treatment relationship, (iii) consistency, (iv) validation, (v) self-reflection, and (vi) motivation. The first four modules are primarily concerned with establishing the within-therapy conditions necessary for change whereas the last two modules are more concerned with establishing the within-patient conditions needed for change to occur. The following section provides a broad overview of these strategies (Chapters 7–12 describe each module in detail).

***Module 1: Establish a Structured Treatment Process:*** All effective treatments for BPD emphasize the importance of a structured process based on an explicit treatment model and a well-defined treatment frame consisting of the therapeutic stance and treatment contract. The stance refers to the interpersonal behaviours, attitudes, responsibilities, and activities that determine how the therapist relates to the patient. Based on current evidence, IMT adopts a supportive, empathic, and validating stance.[18] A key ingredient of structure is the therapeutic contract established prior to treatment that defines collaborative treatment goals and the practical arrangements for therapy.

***Module 2: Establish and Maintain a Collaborative Treatment Relationship:*** If there is an essential ingredient to successful treatment, it is the establishment of a collaborative working relationship between the patient and the therapist. This is given priority because a collaborative relationship provides support, builds motivation, and predicts outcome. With most patients with BPD, it takes time and effort to build a truly collaborative relationship: in many ways collaboration is more the result of effective treatment than a prerequisite for treatment.

***Module 3: Maintain a Consistent Treatment Process:*** Effective outcomes also depend on maintaining a consistent treatment process. Consistency is defined simply as adherence to the frame of therapy. This is why the treatment contract is so important: it provides a frame of reference that helps the therapist to monitor treatment and identify deviations from the frame by either the patient or the therapist. Violations of the frame are relatively common when treating BPD and it is important that they are addressed promptly and supportively.

***Module 4: Promote Validation:*** Validation is defined as recognition, acceptance, and affirmation of the patient's mental states and experiences. Validating interventions make an important contribution to treatment by providing the empathy and support needed to build a collaborative alliance. At the same time, they counter the self-invalidating way of thinking, which is often instilled by invalidating developmental experiences.

***Module 5: Enhance Self-Knowledge and Self-Reflection:*** Most therapies encourage patients to develop a better understanding of how they think, feel, and act, and become more aware of the links between their mental states and problem behaviour. The extent and depth of self-knowledge and self-understanding depend on self-reflection: the capacity to think about and understand one's own mental states and those of others. Impaired self-reflection hinders the development of important aspects of the self that are constructed by reflecting in depth on one's own mental processes. Self-reflection also underlies the capacity for self-regulation and effective goal-directed action.

***Module 6: Build and Maintain Motivation for Change:*** A second within-patient factor necessary for effective outcomes is motivation of change. Patients need to be motivated to seek help and work consistently on their problems. Unfortunately, passivity and low motivation are common consequences of psychosocial adversity. For this reason, motivation cannot be a requirement for treatment. Instead, therapists need to become skilled in building motivation and to make extensive use of motivation-enhancing techniques.

Implementation of the general modules means that treatment is organized around a strong therapeutic relationship characterized by support, empathy, consistency, and validation. Priority is given to the relationship due to the serious problems most patients have experienced with attachment relationships and their consistent difficulties with

interpersonal relationships. The objective is to establish a treatment process that provides a continuous corrective therapeutic experience to counter the lasting effects of psychosocial adversity. This is an important aspect of therapy: change is brought about not only by interventions of one kind or another but also by the way therapy is organized and delivered.

**Phases of Change Model:** The overall course of treatment is divided into safety, containment, regulation and modulation, exploration and change, and integration and synthesis phases that are used to guide the use of specific intervention modules. A challenge for integrated treatment is how to coordinate the use of specific interventions so as to avoid confusion arising from the use of multiple interventions. The phases of change model reduces this problem because each phase addresses a different domain of impairment and hence requires different specific intervention modules. Thus the model describes the sequence in which problems are addressed and specific interventions are used with a general progression from more-structured to less-structured methods.

The first two phases, safety and containment, primarily deal with the symptom domain. The third phase, control and modulation, continues the focus on symptom resolution but deals primarily with emotional dysregulation and associated suicidal and self-harming behaviour. Phase four, exploration and change, focuses primarily on the interpersonal domain using a diverse array of interventions, and phase five, integration and synthesis, deals with the self/identity domain.

The sequence for addressing domains partly reflects the clinical priority given to symptoms including suicidality and self-harm and partly the degree to which problems associated with a given domain are amenable to change. In general, the sequence of symptoms, regulation and modulation, interpersonal, and self/identity reflects increasing stability and resistance to change.

***Phase 1. Safety:*** When treatment begins with the patient in a decompensated crisis state, the immediate concern is to ensure the safety of the patient and others. This is largely achieved by providing structure and support that may be delivered through outpatient treatment and a crisis intervention service, or occasionally through brief in-patient treatment. Interventions are largely generic and non-specific – providing the support and structure as needed to keep the patient safe until the crisis resolves – although medication may also be used with some patients.

***Phase 2. Containment:*** The brief safety phase usually gives way quickly to containment where the goal is to contain and settle emotional and behavioural instability and restore behavioural control. The objectives are to return the patient to the pre-crisis level of functioning as quickly as possible and lay the foundation for further treatment. As with the previous phase, change is achieved through support, empathy, and structure, supplemented if necessary with medication.

***Phase 3. Regulation and Control:*** Crisis resolution and increased stability are usually accompanied by an improved treatment relationship. This makes it possible to begin focusing on improving emotional dysregulation and reducing symptoms including deliberate self-harm, suicidality, and the consequences of trauma. Specific interventions are used to: (i) provide psychoeducation about emotions and emotional dysregulation; (ii) increase awareness, acceptance, and tolerance of emotions; (iii) improve emotion regulation; and (iv) enhance the capacity to process emotions. Emphasis is placed on cognitive-behavioural interventions because of evidence of the effectiveness of these interventions in reducing deliberate self-harm and increasing emotion-regulating skills.[19]