

A “Non-Clinical” Introduction to BPD and DBT

This paper briefly describes the diagnosis of borderline personality disorder and overviews treatment and service issues with a special emphasis on a treatment called dialectical behaviour therapy (DBT). It is intended for managers and administrators who may not be familiar with psychiatric concepts.

Scenario

Sue is a 25-year-old woman with the diagnosis of borderline personality disorder. Sue is a lively and creative woman with many friends. Her friends say she is often the life of the party and they worry about her drinking binges and occasional distressed or abusive phone calls.

Sue often feels depressed and overwhelmed. She binge-eats, frequently cuts herself and occasionally takes serious overdoses that endanger her life and require emergency medical admission. When medically cleared and transferred to a mental health ward, the inpatient staff find her demanding, uncooperative and she can unsettle other patients. The longer she stays in hospital the more agitated she gets. When discharge is mentioned she feels even more overwhelmed and talks of suicide. She has been on a range of antidepressants, a mood stabiliser, sleep medicines and low dose anti-psychotics. Staff disagree about how best to treat her. Some staff sympathise with her history of sexual abuse and violent relationships. Other staff think she only has herself to blame and criticise her anger outbursts and use on alcohol and street drugs.

When back in the community the adult mental health services don't quite know what to do. Her case-manager is feeling particularly stressed as Sue has been kicked out of yet another flat and she wants the case-manager to find her another place to live. Sue's psychiatrist is increasingly concerned about her reliance on addictive sleep medications. Sue doesn't take medicines as prescribed and often complains that her medicines are not working.

What is BPD?

Borderline personality disorder (BPD) is the diagnosis given to people who demonstrate the lifelong pattern of emotional instability, difficult relationships and an unstable sense of who they are. They typically present chronic patterns of impulsive, self-harming and suicidal behaviour. The rates of morbidity (illness and suffering) and completed suicide are comparable to other categories of major mental illness (such as schizophrenia and major mood disorders).

In psychiatry BPD is considered an “Axis II” disorder – a diagnosis of the kind of personality that the client has. Personality refers to persistent ways in which we think, feel, act and relate. This differs from the typical “Axis I” diagnoses that refers to particular conditions or ailments we may suffer from (e.g., depression).

Most people with a BPD diagnosis have other “Axis I” problems as well, such as anxiety disorders, mood disorders, eating disorders and alcohol and drug problems.

While these conditions must also be treated, the typical “Axis I” treatments (such as antidepressants or psychological therapy) do not work very well when a person also qualifies for the BPD diagnosis.

People with the diagnosis of BPD typically use a lot of the health dollar – in mental health services, primary care and hospital services (often following deliberate self-harm or suicide attempts).

Treatment of BPD

Until the early 1990s there was no evidence to suggest that people with a BPD diagnosis could be effectively treated. Services often found themselves reacting to suicidal and aggressive behaviour without a cogent treatment plan and according to treatment approaches developed for Axis-I disorders. There is considerable literature and expert opinion that concludes that this may have unwittingly led to further harm to some people and even impeded recovery. Also the chronic problems of suicidality and anger towards clinicians contributed to clinician burnout and difficulties providing ongoing service.

In 1991 Dr Marsha Linehan and her colleagues published the world’s first randomised controlled trial showing that people with BPD could be effectively treated with an approach she developed called Dialectical Behaviour Therapy (DBT, see below). Since that time there has been an explosion of interest in the field. Expert opinion (such as the American Psychiatric Association) is the treatment of BPD requires specialised psychotherapy (such as DBT) and focussed adjunctive medication.

Access to services

When people with a BPD diagnosis were seen as demanding and untreatable, mental health services in New Zealand (and worldwide) developed a view that such people were not eligible to receive treatment. This view runs contrary to (1) the NZ Ministry of Health MHS purchasing criteria that are independent of the presence or absence of specific diagnostic criteria; (2) “Blueprint” and Ministry priorities being around preventing suicidal behaviours and treating those with complex needs, including alcohol and drug problems; (3) equitable access to health services being a WHO benchmark for measuring the health of a nation; and (4) people with a BPD diagnosis having comparable rates of distress, disability and completed suicide as other major diagnostic groupings in psychiatry. The additional stigma also contributed to the suffering of those with a BPD diagnosis and often tense relationships with MHS providers.

What is DBT?

DBT is an integrative, intensive psychotherapy that draws together elements of cognitive-behavioural therapy, psychoanalytic psychotherapy and eastern meditative practice. It rests on the foundation of a *dialectical philosophy* –the view that there are no absolute truths and that healthy emotional living requires us to live with the tension between competing truths in our lives.

DBT is grounded in a non-judgmental real relationship where both therapist and patient make an informed commitment to the difficult and vital work ahead. DBT pursues an acceptance of ourselves, our emotions, the world, and its unavoidable suffering. DBT relentlessly targets suicidal behaviours and life’s problems as we

need to solve our problems and improve our lives. DBT maintains a hopeful and practical stance. It treats both therapists and the treatment system to prevent burnout and promote healthy outcomes for all involved. DBT involves families, especially with adolescents, as it is very aware of the person's real world context and the related needs of loved ones.

The evidence for DBT

Across multiple countries, treatment centres and trials, DBT has been shown to reduce the frequency and severity of suicidal/self-injurious behaviour, the frequency and duration of psychiatric hospitalisation and client anger, while yielding increases in treatment retention and social/global adjustment. Adaptations of DBT have shown positive results with bulimia, substance abuse, depressed elderly, inpatient BPD and suicidal adolescents. DBT has been found to be significantly more effective than "treatment by experts" who were using non-DBT approaches.

Recent adaptations have extended DBT to various problems of 'emotional dysregulation' such as domestic violence, forensic populations and sex offenders. DBT may now be regarded as a treatment for complex 'multi-diagnostic' and "difficult-to-treat" patients.

DBT has been found to halve the cost of overall services through a combination of *increased* community based care combined with sharply reduced use of inpatient services.

Other Treatments for BPD and related conditions

DBT currently has the strongest empirical standing of any psychotherapy or psychiatric approach to the treatment of persons with BPD. There are also other treatment approaches that have recently established some evidence such as Bateman and Fonagy's Mentalization Based partial hospitalization treatment. It is widely expected that the evidence base for effective therapies will increase dramatically over the coming decade.

New Zealand

DBT has been implemented in New Zealand by some DHBs since 1998. The most established programmes are run by Auckland DHB (the Balance Programme) and Waikato DHB. The five northern DHBs provide some form of DBT programme and in 2006 DBT teams are being established in four Central Region DHBs. NZ outcomes demonstrate mimic international findings and show decreased use of (expensive) inpatient and emergency services.

Like most imported mental health treatments, DBT has yet to be evaluated or adapted in terms of its cultural responsiveness to Maori or Pacific people. This work remains necessary

Two major barriers to developing NZ services have been gaining access to expensive US based DBT training and the lack of Ministry purchasing specifically for services to this patient group which means the initiative is left to the most innovative DHBs.