The Effectiveness Of Different Therapies In Treating Borderline Personality Disorder

Abstract

Borderline Personality Disorder (BPD) is a highly stigmatized and complex disorder affecting 2-6 individuals in every 100, which makes it the most popular of personality types (Van Den Bosch, et al 2005). There is very little evidence-based theory to suggest the best treatment however there have been at-least 17 randomised trials carried out since 1991. Trials have suggested DBT to be extremely successful in reducing tendencies of self-harm (Stepp et al, 2008). However, there is little said about its successfulness in improving other characteristics and defects of BPD, such as cognitive or perception distortions. Other Randomised controlled studies have shown Transference-focussed psychotherapy (TFP) to be a successful treatment. The idea of this research plan is to find out whether a specific treatment approach is most successful. The Independent Variable being the type of treatment and the Dependant Variable the amount of improvement in symptoms. A total of 80 participants will be used (20 for each treatment type). Each participant will be given the same questionnaires to complete in a therapeutic environment at the same intervals. The follow up will consist of telephone contact and postal questionnaires. I expect the results to conclude (Mode) significant difference in the reduction of self-harm and maladaptive coping strategies amongst the DBT group. However, I expect there to be little difference amongst the groups regards other areas of improvement.

Introduction

The name borderline came from the disorder being neither psychotic or psychoneurotic but border lining elements of both (Stern, 1938). The central underlying pathology of Borderline personality disorder (BPD) is disturbed psychological self-organisation and instability. Chronic difficulties in emotional regulation, inter-personal relationships, impulsive and risk-taking behaviours. Clients suffer chronic emptiness, fear of abandonment, disassociation, self-harm and suicidal ideation. Hallucinations and psychosis can occur in extreme emotional unstable times. Thus, it is not surprising that BPD is regarded as one of the most difficult clinical presentations to treat (APA,2013). Many clinicians fear BPD clients, due to clients going from deep love to profound rage, simultaneously fearing abandonment yet unexpectedly attacking (Linhan, 1991., Valentine, et al, 2015). Having impaired understanding of ones' own and others' minds, hyper mentalising others imagining negative intentions, to protect oneself against emotional traumatisation by anticipating impending harm. Plus, the fact 75% of BPD sufferers are self-harmers, the amount of hospitalisation's over suicide attempts and 10% of BPD sufferers success in suicide (Vossler, 2015).

Marsha Linehan (1991) published the first trial regards the treatment of Borderline Personality Disorder (BPD). The trial consisted of 44 females all with BPD, Half were treated using Dialectical Behavioural Therapy (DBT) and half used Treatment As Usual (TAU). The results showed a significant reduction in self-harm, suicide ideation and attempts and improved daily living, from those who participated in DBT. Whereas, the participants under TAU showed little improvement (Albery, 2008., Linehan, 1993). This being the case shows DBT to be superior

however, the fact that this study was carried out by Linehan, the founder of DBT shows bias, which should be taken into consideration (Paris, 2015). Koon (2001) carried out further research on the effectiveness of DBT and found significant reduction in maladaptive behaviours amongst all 20 veterans used in the sample. The validity of data from this study could be questioned due to the participants being paid to participate, it only being a small sample size. Also, the inclusion of SSRI's not consistent with all participants. Therefore, is it the medication or the therapy that has created the improvements. Verheul, et al (2003) carried out a further study on DBT and TAU on 58 females and was repeated in 2005 by Van Den Bosch and Verheul and found DBT to be effective at treatment stage and at clinician follow ups. In 2006 another randomised study revealed DBT superior over community treatments by experts (Linehan et al, 2006). In the content of treating BPD, DBT as the best meta-analytic evidence for efficacy over other treatments, as-well as it being empirically validated (Stoffers, 2012). Thus, it is not surprising DBT is recorded as the most beneficial treatment for BPD by NICE (2018). However, one should not ignore the fact that studies were carried out by Linehan herself or her co-workers and believers does add bias. This being the case further research is needed into the effectiveness of DBT. Thus, this proposal aims to carry out "A comparison between the effectiveness of different therapies offered within East Lancashire NHS, when treating Borderline Personality Disorder".

Basic idea

Quantitative research will be carried out in the form of surveys, to see if there is a significant difference between the different sample groups, regards successfulness of treatment.

The one-tailed hypothesis is, that DBT will show vast improvements over other therapies, in the reduction of self-harm and maladaptive coping strategies, and little statistical differences in other improvement areas.

The Null is, that there is no significant difference in improvement amongst treatment type. The reason for this prediction is due the literature success rate in previous research, the duration of therapy and the amount of varied therapy input.

Methodology

Design

An independent measures design will be used. The Independent Variable will be the type of treatment and the Dependant Variable will be the amount of participant improvement.

Procedure

Work with the British Psychology Association to gain permission to conduct research and seek permission from the NHS. Once permission's granted from the appropriate bodies, each participant would then, in turn be individually informed about the research via their therapist and asked to take part. Once consent was gained, standardised and tested questionnaires would be completed at the first therapy session and handed back to the researcher. To prevent an order effect, I would counter balance the order in which the surveys were completed.

- Outcome measure DBT ways of coping checklist (RWCCL, Vitaliano et al, 1985) scoring system using the averages of relevant items: general dysfunctional and skills.
- The Warwick-Edinburgh Mental Well-being Scale (NHS Health Scotland, 2006) A 14 item Likert scale of well-being and functioning
- Patient Health Questionnaire PHQ-9 (Spitzer, Williams, Kroenke et al, 1999)
- Generalized Anxiety Disorder Assessment (GAD-7) (Spitzer, Kroenke, Williams and Lowe, 2006)
- Work and Social Adjustment Scale (WSAS) (Mundt et al, 2002)

The process would be repeated in the exact same way at the end of therapy (the second to last therapy session)

Telephone contact/postal contact would be made just before the 6th month completion mark, to complete follow up questionnaires.

Results from the questionnaires would be gathered together and analysed.

Ethical Considerations

Work with and gain Permission from the British Psychology Association Board, and work within the ethical guidelines so not to cause any undue harm to the participants (BPS, 2014). Participants over the age of 18 would be used. Consent would be gained. Participants will be given clear instructions, and de-brief (via a leaflet), explaining complete anonymity will be kept, their right to withdraw at any time, data will only be used for this study. Researcher contact details, and help-line numbers and websites will be provided in a leaflet. Individual de-brief at the end would be given too.

Data Analysis

A one-way independent samples ANOVA hypothesis testing technique will be used, to see if there are any significant statistical differences between the means of each sample group. By calculating the central tendencies and the range from each treatment group it will show whether the hypothesis is correct.

ANOVA resembles a t-test for example if 2 samples were used they would both reach the same statistical results. ANOVA analysis has been chosen because a t-test would be unreliable, due to there being more than two treatments/sample groups. Also, using multiple t-tests on more than two samples would have a compounding effect on the error rating of results. Therefore, a ANOVA analysis would retrieve more accurate and reliable results. ANOVA testing works by comparing the variance between each sample; if the between variable is much larger than within the variation, the means of different samples would not be equal (proving the hypothesis correct). If approximately the same, then there is no significant difference (proving the Null).

Predicted results

The researcher predicts that DBT will show vast improvements over other therapies, in the reduction of self-harm and maladaptive coping strategies. Another prediction is that little statistical differences will be found in other areas. The reason for this prediction is from findings

in previous research studies.

Clinical research on BPD began in the early 1980's, with lab experiments. Case studies and randomised trials have been the main approaches to finding successful treatments. Other than the main theory and background research talked about, there is not much regards comparisons of the treatments especially offered by the NHS when treating BPD, thus leading to the hypothesis. However, a common assumption made is that previous trials have been carried out by the founder herself, her co-workers and or believers (Vossler and Moller, 2015). Therefore, if the hypothesis in this proposal was found correct it would back up the theory, regards the success of DBT. If, however the null was proven correct it could suggest bias did occur in previous trials. That or that other literature such as Loveless et al (2016) are correct in suggesting a blended approach such as DBT and SFT (Solution Focussed Therapy) is more fruitful. One study found using the tools and skills from DBT alongside a SFT framework reached the clients goals of reducing symptoms and gaining greater control of emotions, enhancing ones' life (Loveless, 2016). Either way the research found from this proposal would open opportunity for further research within the field of successful treatment types.

The four treatments being analysed are

- DBT - is the 3rd generation of CBT developed by Linehan, specifically for BPD treatment. It emphasis behavioural change, self-acceptance and emotional regulation. Therapy consists of weekly 1-1 hourly therapy sessions, weekly group sessions consisting of mindfulness, emotional regulation, distress tolerance and interpersonal effectiveness modules, set home-work tasks, telephone contact with therapist when in crisis. The duration is 12-18 months.
- Life Skills Training - This is a relatively new approach to treating BPD and other MH issues. It consists of attending group sessions for 24 weeks. It covers the same modules as DBT but they are named differently group.
- CBT - CBT combines cognitive therapy which is about thoughts and perceptions with Behavioural Therapy which addresses learned behaviours. It supports clients to understand how one affects the other and how interpretations of an event causes emotions to be experienced. CBT focusses on specific problems and how to overcome them. Homework is offered between sessions. The main barriers for effectiveness; short term, quick fix approach, non-experienced staff in BPD. High client drop-out rate.
- Treatment as Usual – Regular psychiatric outpatient appointments along with a CMHT eg Care Co-ordinator or mental health nurse input.

Advantages and disadvantages

Advantages to using a quantitative method are that it is cheap to carry out, a larger sample can be accessed. Participants feelings and experiences can still be gained through appropriate questions and approved readily used surveys. Potential emotional harm to participants will hopefully be reduced because surveys are far less intrusive than qualitative interviews. A Quantitative approach would provide Reliability and Validity, and the gathering of statistical data gathered would open possibilities to further research in either quantitative or qualitative form

Limitations to this study are, it is difficult to assess the cause and effect relationship from survey information (eg, medication). According to the National Borderline Personality Disorder

Guidelines 61% take antidepressants, 35% take antipsychotics and 27% take mood stabilizers and 75% take a combination. Thus, is it the therapy, the medication or a combination of both that are having an effect. A random sample may be difficult to obtain, (due to not having a full list of the population, or the full population being able to participate or refuse. Also, participants may not answer truthfully for various reasons. Also, the questions may not all be completed. The main limitations will be in the 6month follow ups - participants may change their address or contact number. Some may fail to fill in or return the questionnaires

Other limitations include pure BPD is unlikely, as there is often an overlap with other diagnosis's thus, gaining the true effectiveness of treatment for BPD becomes difficult as the participants may have co-disorders and other symptoms (Yen and Shea, 2001).