Progress in the treatment of borderline personality disorder (Fonagy and Bateman, 2006)

Re-mapping the course of borderline personality disorder

1 The majority of patients with borderline personality disorder experience a substantial reduction in their symptoms far earlier than previously assumed.

Changing expectations about the effectiveness of treatment

1 Dialectical behaviour therapy: Three randomised controlled trials (for a review, see Lieb et al, 2004) reported significant dramatic reductions in attempted suicide when contrasted with usual treatment (relative risk=-1.38, 95% CI 1.13–1.69).

2 Psycho-dynamically oriented interventions: A randomised controlled trial of treatment of borderline personality disorder in a psychotherapeutically orientated day hospital offering modified individual and group psychoanalytical psychotherapy (Bateman & Fonagy, 1999, 2001) has shown significant and enduring changes in mood states and interpersonal functioning associated with an 18-month programme (effect size=-2.36, 95% CI 73.18 to 71.54). benefits steady!

3 The trial contrasted transference-focused psychotherapy, dialectical behaviour therapy and supportive psychotherapy. There was significant and equal benefit from all the interventions, although early drop-out rates were higher for dialectical behaviour therapy than for the other treatments (Clarkin et al, 2004).

Reality of iatrogenic harm

Iatrogenic, psychotherapy and borderline personality disorders

1 Traditional psychotherapeutic approaches depend for their effectiveness on the capacity of the individual to consider their experience of their own

Findings

1 Overall, DBT clients reported engaging in less self-directed violence compared to controls, and also reported fewer incidents of seeking psychiatric crisis services (i.e., inpatient psychiatric hospitalization, emergency department visits).

Discussion

1 Foremost, this meta-analytic review demonstrates the effectiveness of DBT for the treatment of self-directed violence, and in reducing the frequency of accessing psychiatric crisis intervention services. (samples including adults, pediatric populations, DBT trails, inpatient and outpatient settings, with/without suicide or NSSI.
2 The mean effect of DBT pooled across all studies was modest.
3 There is not a robust effect of DBT with regard to suicidal ideation across controlled trials.
4 The importance of including measures of suicidal ideation in DBT studies as well as the need for additional clinical development of optimal strategies for mitigating durable patterns of suicidal ideation that may not resolve during the course of DBT.
5 DBT as a first-line treatment for the prevention of suicidal behaviour and psychiatric emergency care in diverse clinical populations, including high-risk and acutely suicidal clients, for whom “chronic, aversive emotional dysregulation” (p.14) and perceptions of life as “intolerable and unsolvable” (p.15) are primary drivers of suicidality (Linehan, 1993).

Limitations: small sample size, potential incomplete of studies, only controlled trails included (transferability to applied clinical settings)

The Structure of Phenotypic Personality Traits (Goldberg, 1993)

These Big-Five factors have traditionally been numbered and labelled, Factor I, Surgency (or **Extraversion**); Factor II, **Agreeableness**; Factor III, **Conscientiousness**; Factor IV, Emotional Stability (vs. **Neuroticism**); and Factor V, Culture.1 More recently, Factor V has been reinterpreted as Intellect (e.g., Digman & Takemoto-Chock, 1981; Peabody & Goldberg, 1989) and as **Openness to Experience** (e.g., McCrae & Costa, 1987).

When viewed hierarchically, it should be clear that proponents of the five-factor model have never intended to reduce the rich tapestry of personality to a mere five traits (e.g., Shweder & Sullivan, 1990). Rather, they seek to provide a scientifically compelling framework in which to organize the myriad individual differences that characterize humankind.

The Accidental Discoverer (Fiske), The True Fathers (Tupes and Christal), Other Early Explorers (Borgatta and Smith): contributed but no follow-up research.

Critics:

1. Norman, 1963: using a representative subset of the total English personality-trait lexicon would uncover dimensions beyond the Big Five (tested wrong by Goldberg, 1990).
2. Recent critiques:

The Assimilators (Costa/McCrae and Wiggins)

The five-factor model of personality and its relevance to personality disorders (Costa and McCrae, 1992)

This categorical, medical model of personality disorders (DSM-5) has frequently been criticized (e.g., Eysenck, Wakefield, & Friedman, 1983; Kato, 1988).

Dimensional approaches to personality disorders emphasize continuity with normal variations in personality traits and, if adopted, could facilitate an integration of research on personality disorders with decades of research on normal personality structure and measurement.

This article summarizes evidence on the validity, comprehensiveness, universality, heritability, and stability of these five factors, and reviews instruments for their assessment.

The five-factor model of personality

Personality traits can be defined as "dimensions of individual differences in tendencies to show consistent patterns of thoughts, feelings, and actions' (McCrae & Costa, 1990, p. 23).

Consensual validity

1 The most fundamental question about the five factors is whether they are meaningful and scientifically useful constructs, or whether they are mere artifacts.
2 These correlations (by McCrae and Costa, 1989a) are far from unity and considerably less than the reliabilities of the measures. Thus, self-reports and (others) ratings are not interchangeable.
3 They are, however, all meaningful and valid measures of traits, and even better measures might be obtained by aggregating them.