



PERSPECTIVE/ PERSPETIVA

## Borderline Personality Disorder Programme: The São João University Hospital Centre Experience

### Programa de Intervenção em Perturbação de Personalidade Borderline: A Experiência do Centro Hospitalar Universitário de São João

✉ BERTA RAMOS\*<sup>1</sup>, FILIPA SANTOS MARTINS<sup>1</sup>, EVA OSÓRIO<sup>1,2</sup>, RAQUEL PEDROSA<sup>1,2</sup>, CÁTIA GUERRA<sup>1,2</sup>

<sup>1</sup> Serviço de Psiquiatria, Centro Hospitalar Universitário de São João, Porto, Portugal

<sup>2</sup> Departamento de Neurociências Clínicas e Saúde Mental, Faculdade de Medicina da Universidade do Porto, Porto, Portugal

**Palavras-chave:** Perturbação de Personalidade Borderline/tratamento; Psicoterapia; Terapia Comportamental

**Keywords:** Behavior Therapy; Borderline Personality Disorder/therapy; Psychotherapy

Borderline personality disorder (BPD) is a complex mental illness that is characterized by a pervasive pattern of instability in interpersonal relationships, self-image, affect, and behavioral dysregulation.<sup>1</sup> Not long ago, BPD was viewed as an ‘untreatable’ disorder. These patients can be demanding and unstable, particularly when the treatment is poorly structured and placed in general care units.<sup>2</sup> However, they can be successfully treated and different evidence-based psychotherapies, namely transference focused therapy, dialectical behavior therapy, mentalization based treatment and schema therapy have been shown to be efficacious and cost-effective.<sup>3</sup>

Presently, the creation of specialized BPD models of treatment, which includes a structured, integrated and coordinated psychological and psychiatric care, is recommended by NICE guidelines.<sup>4</sup> Not all patients need a specific and intensive treatment, but the ones with more severe symptoms do.<sup>5</sup>

In 2013, a programme based on the McLean Hospital model<sup>5</sup> was created in the Psychiatry Department at São João University Hospital Centre, becoming the first BPD specialized treatment programme created in Portugal. This is a challenging and motivating programme which has been a very useful instrument in the patients’ treatment. The

main goals are to promote emotional regulation, modify behaviors (impulsive behaviors), improve interpersonal relationships, intrapsychic reorganization, and autonomy. Currently, the therapeutic team is constituted by three psychiatrists, two clinical psychologists and one occupational therapist. It is complemented by psychiatric residents from all over the country which come to learn and work with us. The treatment starts with an initial evaluation performed by a psychiatrist and a psychologist. If the diagnosis is confirmed, the patient is included in a specific level of care according to the symptom’s severity. At this point, the patient is attributed a main therapist, usually the psychiatrist that did the initial evaluation. The main therapist is responsible for case assessment, developing the treatment plan, performing therapy, and communicating with family. The programme consists in a structured treatment with four levels of care (IV. Hospital Admission, III. Residential/Day Hospital, II. Intensive outpatient treatment and I. Outpatient treatment) and focuses on both residential and intensive outpatient treatments. These levels are not sequential, and patients can be admitted to the programme at any level. The fourth level consists in hospital treatment in the psychiatry general inpatient clinic. The hospitalization offers a necessary containment to acute agitation and danger of

Recebido/Received: 2022-02-26

Aceite/Accepted: 2022-12-01

Publicado Online/Published Online: 2022-12-22

Publicado/Published: 2022-12-30

\* Autor Correspondente/Corresponding Author: Berta Ramos | Centro Hospitalar Universitário de São João | bertamramos@gmail.com

© Autor(es) (ou seu(s) empregador(es)) e Revista SPPSM 2022. Reutilização permitida de acordo com CC BY-NC. Nenhuma reutilização comercial.

© Author(s) (or their employer(s)) and SPPSM Journal 2022. Re-use permitted under CC BY-NC. No commercial re-use.

suicidal or violent acts. The length of treatment at this level should be as short as possible.

The third level includes residential care and day hospital treatment. The residential care developed in the Youth Residential Unity is particularly intended for patients with severe symptomatology and poor social, professional or scholar functioning. This level of care is focused on stabilizing daily routine, identifying or modifying misbehaviors (impulsivity) and interpersonal traits (tolerance, affection recognition), and on initiating a vocational rehabilitation. Patients are provided with individual psychotherapy based on mentalization based therapy (MBT) sessions, which happens weekly. Additionally, several group therapies are included in this level of care, such as BPD group (once-a-week group combining dialectical behavior therapy (DBT) and MBT techniques); narrative therapy, dramatic therapy, mindfulness-based therapy, vocational coaching, and Interpersonal skills training. The Day hospital treatment is intended for patients which can take care of basic daily activities but are in the need of a structured psychotherapeutic treatment. The patients attend the day hospital for three to five days a week, and the specific activities include individual psychotherapy in the psychiatric consultation, two MBT psychotherapeutic groups, and occupational therapy intervention. The duration of the treatment ranges from 12 to 24 weeks in residential care, and from 6 to 36 weeks in day hospital.

The second level is settled on an intensive ambulatory treatment. At this level, patients are monitored weekly or fortnightly with individual psychotherapy and they can join the MBT outpatient group. The main goals are also developed in several scopes, such as psychotherapeutic, vocational, behavioral, and interpersonal. In individual psychotherapy a MBT approach is used. In the beginning, a case formulation is written and given to the patient and a crises plan is developed. The initial formulation is made by the individual clinician after the first few sessions and discussion with the treatment team. It is then given in written form to the patient for further consideration. The case formulation presents difficulties, strengths, and identification of mentalization patterns. It also includes strategies to manage risk and common aims for the treatment. The aim of the following therapy sessions is to discuss the crises, understand patient's feelings, thoughts, and behavior and find better strategies to cope with them. The outpatient MBT group is scheduled once a week. After a joining phase, the situations brought by the patients are addressed through a MBT perspective to develop the mentalization capacity. The extent of this level of treatment is variable, ranging on average between 18 to 24 months.

Finally, the first level corresponds to outpatient treatment. It aims to consolidate the improvements on the interpersonal and intrapsychic functioning. Consultations can be once a month or every three months.

In this BPD treatment programme, the involvement of the families and close friends is transversal to the treatment. It concerns psychoeducational interventions (single family and family group) and family therapy. The family group aims to increase family involvement, to provide

psychoeducation, to approach attitudes regarding emotional involvement, to train communication and problem-solving skills and to reduce expressed emotion within the family.<sup>6</sup> It also contributes to family support and reduces family isolation and stigma.<sup>3,7</sup> Its methodology is influenced by McLean Hospital program,<sup>5</sup> TARA Method<sup>6</sup> and Reno program.<sup>7</sup> Mostly, other family interventions are designed specifically to help family members of patients with BPD and have obtained empirical support. In general, all of these have been shown to be useful for reducing emotional burnout, feelings of pain and guilt, overload, and depressive-anxious symptoms, and for improving relationship skills and the family climate.<sup>8</sup> There was not possible to find any study which compares between family intervention with and without the patient present. Since the beginning of the family group in our programme the functioning has evolved with the families' needs and characteristics, which shows that a regular and flexible family therapy is an essential part of the BPD treatment. Initially it involved patients and family members, however this option raised the levels of expressed emotion. Therefore, currently the group is only constituted by family members and has an open structure.

Since 2013 until 2021, a total of 104 BPD patients were admitted to this programme, 99 (95%) of which are female. These patients had a mean age of 33 years old, when they engaged in the programme. Seventeen (16%) patients were admitted at least once to the fourth level of care (hospital admission), 28 (27%) were admitted in the residential care and 10 (10%) to the day hospital. Sixty-four (62%) patients engaged in the intensive ambulatory treatment and 41 (39%) in outpatient care. During the follow-up 1% of the patients have been expelled, 33% have abandoned the programme, and 10% have been discharged due psychotherapeutic stabilization. Regarding group therapy, 18% of the patients have engaged in the MBT group, and 28% of the families have participated in the multi-family group.

The dropout rate of this programme is high, and it occurs mostly on the first three months of the treatment, which is similar when compared to other programmes.<sup>9-11</sup> According to them, the high dropout rate in the early phase of the treatment has been found to be strongly associated with patients' first impression of the programme and the staff, to the patients' expectations regarding the effectiveness of the treatment and their motivation for change.<sup>9</sup> Also, high impulsivity and comorbidity with eating disorders and cocaine use disorder were clinical variables predictors of dropout.<sup>9,11</sup> Furthermore, some studies revealed that patients' unfavorable external circumstances are significant predictors of dropout, such as logistic factors (work engagements that collide with session times) and external pressure by significant others (family/partner).<sup>9</sup> It was also considered the specific patient-therapist relationship and the severity of borderline pathology crucial in the drop-out problem.<sup>9</sup> We think that some of the difficulties found in previous studies are shared with our programme. Many patients oriented to our programme have already been in psychiatric treatment before, present severe diseases, and the period of time between the first evaluation and the admission is, on

average, two months. We believe that this initial phase may interfere in the attitude towards the treatment and in the therapeutic alliance. This time of evaluation is not only dependent on patient's attendance to scheduled appointments but also on the fact that we have a small therapeutic team that is not totally dedicated to this programme. We do not believe that specific patient-therapist relationship may be crucial in the drop-out problem since the number of drop-out patients is similar between the different psychiatrists of the programme.

BPD patients need multidisciplinary care, which implies teamwork among psychiatrists, psychologists and occupational therapists. The possibility of different levels of treatment and different psychotherapeutic approaches may

be desirable for different patients, or the same patient may need different interventions over time, which is provided by this programme. This programme has the advantage of adapting the therapy to the patients' needs without losing structure. Also, the principle of split treatments, meaning two complementary forms of treatment, can diminish the dropouts and enhance effectiveness in reducing symptomatology.<sup>5,12,13</sup>

In the future, it could be important to shorten the evaluation period for admission to the programme, to offer help in finding strategies to overcome obstacles to access treatment, to compare patients who continued treatment with patients who dropped out and to evaluate the efficacy of the programme.

### Declaração de Contribuição

**BR e FSM:** Contribuição substancial na redação do artigo e aprovação final da versão a ser publicada

**EO, RP e CG:** Contribuição intelectual substancial, revisão crítica do manuscrito e aprovação final da versão a ser publicada.

### Contributorship Statement

**BR and FSM:** Substantial contribution to the writing of the paper and final approval of the version to be publish.

**EO, RP and CG:** Substantial intellectual contribution, critical review of the manuscript and final approval of the version to be publish.

### Responsabilidades Éticas

**Conflitos de Interesse:** Os autores declaram não possuir conflitos de interesse.

**Suporte Financeiro:** O presente trabalho não foi suportado por nenhum subsidio o bolsa ou bolsa.

**Proveniência e Revisão por Pares:** Não comissionado; revisão externa por pares.

### Ethical Disclosures

**Conflicts of Interest:** The authors have no conflicts of interest to declare.

**Financial Support:** This work has not received any contribution grant or scholarship.

**Provenance and Peer Review:** Not commissioned; externally peer reviewed.

### References

1. American Psychiatric Association Diagnostic and statistical manual of mental disorders. 5th edition. Chicago: APA; 2013.
2. Levy KN, McMMain S, Bateman A, Clouthier T. Treatment of Borderline Personality Disorder. *Psychiatr Clin North Am.* 2018;41:711-28. doi: 10.1016/j.psc.2018.07.011.
3. Gunderson JG, Links P, editor. Handbook of good psychiatric management for borderline personality disorder. Chicago: American Psychiatric Publishing; 2014.
4. Ali S, Findlay C. A review of NICE guidelines on the management of borderline personality disorder. *Br J Med Pract.* 2016;9: a909
5. Gunderson JG, Herpertz SC, Skodol AE, Torgersen S, Zanarini MC. Borderline personality disorder. *Nat Rev Dis Primers.* 2018;4:18029. doi: 10.1038/nrdp.2018.29.
6. Porr V. Overcoming borderline personality disorder: A family guide for healing and change. Oxford: Oxford University Press; 2010.
7. Hoffman PD, Fruzzetti AE. Advances in interventions for families with a relative with a personality disorder diagnosis. *Curr Psychiatry Rep.* 2007;9:68-73. doi: 10.1007/s11920-007-0012-z.
8. Guillén V, Díaz-García A, Mira A, García-Palacios A, Escrivá-Martínez T, Baños R, et al. Interventions for family members and carers of patients with borderline personality disorder: a systematic review. *Fam Process.* 2021;60:134-44. doi: 10.1111/famp.12537.
9. Martino F, Menchetti M, Pozzi E, Berardi D. Predictors of dropout among personality disorders in a specialist outpatients psychosocial treatment: a preliminary study. *Psychiatry Clin Neurosci.* 2012;66:180-6. doi: 10.1111/j.1440-1819.2012.02329.x.

10. Yeomans FE, Gutfreund J, Selzer MA, Clarkin JF, Hull JW, Smith TE. Related to drop-outs by borderline patients: treatment contract and therapeutic alliance. *J Psychother Pract Res.* 1994;3:16-24.
11. Carmona I Farrés C, Pascual JC, Elices M, Navarro H, Martin Blanco A, Soler J. Factors predicting early dropout from dialectical behaviour therapy in individuals with borderline personality disorder. *Actas Esp Psiquiatr.* 2018;46:226-33.
12. van den Bosch LM, Sinnaeve R, Hakkaart-van Roijen L, van Furth EF. Efficacy and cost-effectiveness of an experimental short-term inpatient Dialectical Behavior Therapy (DBT) program: study protocol for a randomized controlled trial. *Trials.* 2014;15:152. doi: 10.1186/1745-6215-15-152.
13. Bateman A, Fonagy P. Randomized controlled trial of outpatient mentalization-based treatment versus structured clinical management for borderline personality disorder. *Am J Psychiatry.* 2009;166:1355-64. doi: 10.1186/s12888-016-1000-9.