

The effectiveness of psychoanalytic- interactional psychotherapy in borderline personality disorder

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Different methods are available for the psychotherapeutic treatment of patients with severe personality disorders. In Germany, a special form of dynamically oriented therapy called psychoanalytic-interactional psychotherapy or method (PiM) has been clinically applied for many years. PiM was derived from psychoanalytic therapy and has been specifically adapted for the treatment of severely disordered patients, for example, patients with borderline personality disorders, prepsychotic disorders, addictions, and perversions. In a naturalistic study, the effectiveness of PiM was tested in a sample of patients with borderline personality disorders (N = 132). The patients were treated in the Clinic Tiefenbrunn near Göttingen. Standardized, reliable, and valid diagnostic instruments were used to study the treatment effects. According to the results, PiM achieved significant improvements in target symptoms, general symptoms, interpersonal problems, and contentedness with life. The results are discussed with regard to the treatment of severely disordered patients. (Bulletin of the Menninger Clinic, 74[3], 206-218)

Patients with severe mental disorders such as borderline or narcissistic personality disorder, substance related disorders, or prepsychotic disorders make high demands on both therapist

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and treatment. Both clinical experience and empirical data (e.g., Wallerstein, 1989) suggest that it is necessary to adapt the psychotherapeutic treatment to the specific problems and needs of these patients. Representatives of psychodynamic psychotherapy were the first to develop specifically adapted methods of treatment (for a review, see, for example, Kernberg, 1995). At present, several manual-guided psychodynamic treatments for patients with severe mental disorders exist. Empirical evidence is available for Transference Focused Psychotherapy (TFP; Clarkin, Levy, Lenzenweger, & Kernberg, 2007; Clarkin, Yeomans, & Kernberg, 1999) and Mentalization-Based Therapy (MBT; Bateman & Fonagy, 1999, 2004). Recently data supporting the efficacy of another psychodynamic treatment for patients with borderline personality disorder were published by Gregory et al. (2008). Within the cognitive-behavioral field, treatment approaches were developed by Beck and Freeman (1993) and Linehan (1987). However, there is a need for further evidence-based treatments for patients with severe mental disorders (Binks et al., 2006).

In Germany, a specific psychodynamic method for the treatment of severely disordered patients who show a lack of essential psychic functions due to structural deficits in personality organization and who do not meet the requirements necessary to engage in an analytic process has been developed by Heigl-Evers and Heigl (1983; Heigl-Evers & Streeck, 1985; Streeck, 2002, 2007). Because the focus of diagnostic and therapeutic attention is primarily on interaction, it was named Psychoanalytic-Interactional Psychotherapy or Psychoanalytic-Interactional Method (PiM).¹ In PiM, the perspective of psychoanalysis which focuses on conscious and subconscious intra-psychic processes is thus amplified by a perspective that focuses on interpersonal processes, including the interaction in the here-and-now. PiM can be applied in an individual and in a group setting. In Germany, PiM is one of the most commonly applied treatments, especially in inpatient psychotherapy for patients with severe mental disorders whose

1. The method is based on psychoanalytic theories and clinical experiences but uses therapeutic techniques that are quite different from psychoanalysis. Although the method today might better be named Psychodynamic Interactional Psychotherapy, the original name has been kept.

disturbances appear in large part in the interpersonal realm and for whom development of basic psychic functions has priority.

The interventions used in PiM are described in treatment manuals (Streeck, 2002, 2007; Streeck & Leichsenring, 2009). The main principle of interventions used in PiM is called “responsive mode.” In the responsive mode, the therapist selectively verbalizes experiences and affects that she perceives in herself, either in virtually identifying with one of the actors within scenes the patient is talking about or in response to the patient in the here-and-now.

Vignette 1

A patient showed serious self-destructive behavior and suffered from severe social anxieties. Her personality structure exhibited relevant deficits due to considerable neglect during her early childhood. Getting into states of stress, she often cut herself deeply and practiced life-threatening abuse of drugs to increase urine output. On weekends, when she could not reach her therapist, she withdrew and even abandoned members of the therapeutic staff with whom she seemed to have been in good contact shortly before. This often caused problematic situations and made it urgent to take steps to prevent her from severe harm. But even when she was better able to control her self-injurious behavior her splitting mechanisms often ran into object loss. The therapist tried to anticipate consecutive problems before a few days' absence, pointing to the splitting and object loss of the patient. Several minutes before the end of the last hour, she said: “I bother what will happen when our time will be over today. I am afraid that when you have gone, our good experiences here today will get lost for you and that until next week when we meet again there will not be much left. Meanwhile, I will certainly worry about that when I think of you.”

The therapist knew that the patient had great difficulty in sustaining the good relationship with the therapist when she did not meet her wishes or if she was unavailable, and that sometimes the patient was even unable to remember her. Therefore the therapist herself took over the function of keeping up the relationship and

told the patient that from time to time she would think of her during her absence.

Vignette 2

Another patient had some difficulty recognizing that the unfriendly behavior of people around him was a reaction to his own often tactless and sometimes uncontrolled behavior. When the patient for the umpteenth time ranted and raved at the therapist and devalued him, the therapist said: "I can see that today you are again dissatisfied with me. Perhaps you assume that I do not care about your critique. Sometimes I am worked up when I have the impression that you do not care at all how I could experience your devaluing attitude against me."

Thus, the therapist allows the patient selectively after psychotherapeutic reflection to participate in the experiences and feelings that she perceives in herself as a reaction to the behavior presented by the patient (e.g., "I am wondering how this woman has experienced the way you behaved towards her"; "I feel ... when you attack me in this way"). Thus, interventions in the responsive mode are characterized by the fact that the psychotherapist lets the patient perceive her in part as another subject. From a psychoanalytic perspective, the therapist conveys the patient-selected aspects of his countertransference, a behavior that is discussed under the heading of transparency or self-disclosure (Gediman, 2006; Meissner, 2002).

In PiM, selective self-disclosure is neither employed spontaneously nor does it aim at making the therapeutic dialogue more egalitarian. Nor does self-disclosure imply that the therapist conveys her countertransference in any way she likes. On the contrary, the therapist has to decide if any and which aspects of her countertransference may be beneficial for making the patient's interpersonal world more transparent and for helping him to develop psychic functions which up to then are not available.

Interventions in the responsive mode thus serve several functions:

- a responding intervention emphasizes the difference between self and object;

- in a selective way, a responding intervention expresses the effects that the patient's behavior exerts on the psychotherapist and on her experiences;
- by a responding intervention, the patient is shown how he contributes by his behavior to the dysfunctional interpersonal circles in which he has been repeatedly involved;
- interventions of this kind foster the development of reflective functioning;
- responding interventions show the patient that the therapist does not allow him to involve her in destructive and exploiting experiences, but is able to protect her own boundaries (Ott, 2001). Thus, many severely disordered patients are relieved from their overpowering fear concerning the strength of their impulses and affects.

Compared to other psychodynamic approaches for the treatment of severe personality, the main differences can be described as follows. In contrast to TFP, PiM does not make use of interpretations, but uses the "responsive mode" as described above. Compared to MBT, behaviors and feelings are not attributed to motives or other characteristics of the individual person, but to the interactional context in which these behaviors and feelings occur. However, with regard to the interventions, PiM is closer to MBT than to TFP.

This article presents the results of an effectiveness study of PiM in patients with borderline personality disorder. As a first step of a research program, we carried out an effectiveness study evaluating the results of PiM in an inpatient treatment of borderline patients. However, PiM can be applied both in outpatient and inpatient settings and is not restricted to the treatment of borderline patients, but can be used to treat other forms of severe mental disorders. As a second step of evaluation, we are presently carrying out a randomized controlled trial (RCT) of PiM in patients with Cluster B personality disorders.

TABLE 1. Description of the sample of patients with
borderline personality disorder ($N = 132$)

Age (M, SD)	30.3 (9.51)
Women (%)	86
Disability (%)	62
Suicide attempt prior to admission (%)	21
Suicide attempt ever (%)	36
Self-mutilation prior to admission (%)	54
Self-mutilation ever (%)	74
History of substance abuse or dependence (%)	55
BSS ≥ 6 (%)	85
BSS ≥ 8 (%)	40
Total number of psychiatric	
ICD-10 diagnoses (M)	3.52
4 ICD-10-Diagnoses (%)	31.8
5 ICD-10-Diagnoses (%)	21.2

Method

The study was carried out in the clinic of Tiefenbrunn near Göttingen. In Tiefenbrunn, patients with severe mental disorders are treated by PiM both in an individual and in a group setting. The treatment follows the principles described above (Streck 2002, 2007). In the clinic of Tiefenbrunn, therapists are specifically trained in PiM. Using videotaped treatment sessions, therapists are continually supervised by highly experienced therapists who contributed to the development of PiM.

Sample

For the present study, all patients diagnosed with borderline personality disorder according to ICD-10 (Dilling & Freyberger, 2001; Dilling, Mombour, & Schmidt, 1993) who were treated between 2001 and 2004 were included ($N = 132$). Patient characteristics are given in Table 1.

Length and dose of treatment

For the sample of borderline patients, the treatment lasted for an average of 87.8 days ($SD = 43.1$). The patients received an average of 45.5 ($SD = 26.6$) (individual or group) sessions. At present, evidence for the psychopharmacological treatment of borderline

patients is not convincing (Binks et al., 2006b). At the clinic of Tiefenbrunn, patients with borderline personality disorders are treated primarily by means of psychotherapy. In cases of severe symptoms of depression or anxiety, additional psychopharmacological treatment may be given temporarily.

Assessment

In the clinic of Tiefenbrunn, all therapists are trained in giving psychiatric diagnoses according to ICD-10. To ensure reliability of diagnoses, the research criteria of ICD-10 are used (Dilling & Freiberger, 2001). As an observer-rated measure of global impairment, a rating scale developed by Schepank (1995) is used (Beeinträchtigungs-Schwere-Score [BSS], Severity of Impairment Score). A BSS score of 6 or more is regarded as indicative of a severe or extraordinarily severe disorder (Schepank, 1995). Interrater reliability for the BSS is ensured by rater training. For this study, the following outcome measures were applied: Symptom Check List SCL-90-R (Derogatis, Lipman, Rickels, Uhlenhuth, & Covi, 1974; Franke, 1995), Inventory of Interpersonal Problems (IIP; Horowitz, Straub, & Kordy, 1994), the Questionnaire for Contentedness with Life (FLZ; Fahrenberg, Myrtek, Wilk, & Krentel, 1986), and the Questionnaire for Changes in Experiencing and Behavior (VEV; Zielke & Kopf-Mehnert, 1978). To assess the patients' individual problems, a goal attainment scaling (GAS; Kiresuk & Lund, 1979) was used. For the goal attainment scaling, patients were asked at admission to write down three problems that were presently most distressing and to rate the severity of these problems on a 5-point Likert scale. At discharge, patients were asked to again rate the severity of the initially formulated three problems. For this study, we used the mean score averaged over the three problems.

Psychoanalytic-interactional psychotherapy in BPD

TABLE 2. Results of inpatient psychoanalytic-interactional therapy in patients with borderline personality disorder

	Admission N = 132 M SD	Discharge N = 132 M SD	Pre-Post effect size (d)
SCL-90-R GSI	1.79 0.69	1.31 0.74	0.70**
Inventory of Interpersonal Problems IIP- total	15.10 3.79	12.97 4.73	0.56**
Contentedness with Life (FLZ)	39.19 8.04	34.58 9.37	0.57**
Goal Attainment Scaling (GAS)	3.27 0.63	2.19 0.84	1.73**
Severity of Impairment Score BSS-total	7.14 1.71	5.66 1.81	0.87**

* $p < 0.05$, ** $p < 0.01$.

Results

Characteristics of the sample

According to the results, the patient sample included can be regarded as severely disturbed: 85% of the patients showed a BSS score ≥ 6 at admission. Furthermore, the rates of disability, suicide attempts, self-mutilation, and substance abuse prior to admission were high (Table 1). The rate of comorbid disorders was high as well. In 81% of the patient sample, three or more psychiatric diagnoses according to ICD-10 were given at admission (Table 1). Mean symptom severity assessed by the (GSI) of the SCL-90-R was 1.79 (Table 2). Thus, symptom severity was more than five times as high as the values reported by Franke (1995, p. 86) for the general population ($M = 0.33$, $SD = 0.25$).

Treatment effects

From admission to discharge, severity of psychiatric symptoms as assessed by the Global Severity Index (GSI) decreased significantly (Table 2). The improvement in the GSI corresponds to an effect size (d) assessed according to Cohen (1988) of 0.70 (Table 2). Effect sizes can be transformed into percentages of patients improved (Cohen, 1988; Roth & Fonagy, 2005). Accordingly, the borderline patients treated by inpatient PiM were better off

than 76% of the patients before therapy. Interpersonal problems assessed by the IIP decreased significantly during treatment (Table 2). This is true for contentedness with life (FLZ) and general well-being (VEV; $M = 189.54$, $SD = 34.90$, $p < 0.05$; Zielke & Kopf-Mehnert, 1978). Furthermore, observer-rated impairment decreased significantly (BSS, Table 2). Particularly large effect sizes were achieved with regard to the individual problems formulated by the patients (GAS, $d = 1.73$). The effect size of 1.73 corresponds to a very large effect size. It is more than twice as large as the effect of 0.80, which is regarded as a large effect (Cohen, 1988).

Discussion

The present study addressed the effectiveness of inpatient PiM in patients with borderline personality disorders. According to the results, the treatment yielded significant improvements in symptoms, interpersonal problems, contentedness with life, and general well-being. Particularly large effect sizes were found for the most distressing problems individually formulated by the patients (GAS). However, in spite of the significant improvements and the large effect sizes that were achieved, the patients cannot be regarded as remitted. The severity of symptoms (GSI) decreased significantly from 1.79 at admission to 1.31 at discharge. However, a GSI of 1.31 is still indicative of high symptom severity. Thus, further outpatient treatment is required after discharge. Furthermore, follow-up studies are required to examine the stability of the treatment effects.

This article presented results from a naturalistic study that was carried out under the conditions of clinical practice. Thus, the results can be assumed to be clinically representative (Shadish, Matt, Navarro, & Phillips, 2000). In an effectiveness study, factors influencing outcome cannot be controlled to the same extent as in a randomized controlled trial (RCT). For this reason, the improvements achieved by the patients can only be attributed to the treatment package as a whole, but not to specific elements of the inpatient treatment, such as individual treatment, group treatment, or milieu effects. However, there is evidence that ef-

fectiveness (observational) studies do not systematically overestimate treatment effects (Benson & Hartz, 2000; Concato, Sha, & Horowitz, 2000; Shadish et al., 2000; Leichsenring & Rabung, 2008). In order to be able to attribute the treatment effects to PiM, we are presently carrying out an RCT comparing PiM and treatment as usual in patients with cluster B personality disorders.

RCTs and effectiveness studies refer to different intended applications (laboratory vs. field), they are in a complementary rather than in a rival relationship (Leichsenring, 2004). RCTs examine if a treatment works under controlled experimental conditions, whereas effectiveness studies test if a treatment works under the conditions of clinical practice.

Patients with borderline personality disorder are difficult-to-treat patients. The results presented here show that these patients can benefit from PiM applied in an inpatient setting. As described here, PiM is not limited to the treatment of borderline personality disorder. It can be applied to other forms of severe mental disorders as well, especially for patients who suffer from the effects of relevant lack of psychic functions due to impairments of the development of personality structure and come to the fore primarily in interpersonal relations. The responsive mode of interventions that is characteristic for PiM makes countertransference transparent in a highly selective manner on the condition that the patient will tolerate the intervention and helps the patient to develop psychic functions necessary to participate in reciprocal social interaction. PiM can be applied in inpatient and outpatient settings, and in individual and in group settings. Thus, PiM may complement the presently available psychodynamic treatments for severe mental disorders such as TFP and MBT. However, further research on PiM is needed.

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