Evidence-based psychological interventions for borderline personality disorder in the United Kingdom. Who falls through the gaps?

Over the past fifteen years, access to evidence-based psychological interventions (EBPIs) for borderline personality disorder has dramatically increased in the United Kingdom. However, some patients continue to fall through the gaps. This paper presents a novel analysis of evidence on patients who are currently unable to benefit from EBPIs and explores possible solutions, with particular reference to dialectical behaviour therapy and mentalization based therapy. At one end of the spectrum, patients with less severe difficulties often do not meet the threshold for receiving EBPIs in dedicated personality disorder services. The nascent evidence base for a possible solution — implementation of streamlined versions of EBPIs in generic mental health or even primary care services — is reviewed. At the other end, a sizeable minority of patients receiving long-term EBPIs discontinue treatment prematurely and/or experience poor outcomes. This is a highly distressing experience with potential for iatrogenesis — yet the evidence base for what to do next is non-existent and follow-on treatment pathways in services are unclear. Difficulties in the therapeutic alliance, a failure to overcome epistemic hypervigilance, and therapist non-adherence to the model are reviewed as possible contributing factors. The importance of understanding the patient perspective on what happened, considering the role of both patient and therapist in contributing to difficulties, and offering patients a choice in specifying their onward treatment, is discussed. Finally, increasing access to trauma-focussed EBPIs for post-traumatic stress disorder is recommended as an avenue for the future.

Keywords: Borderline personality disorder; Psychological therapies; Dialectical behaviour therapy; Mentalization-based therapy

Corresponding author: Dr Kirsten Barnicot, School of Health Sciences, City University of London, Myddleton Street Building, 1 Myddleton Street, London, EC1R 1UW, United Kingdom. Email: Kirsten.Barnicot@city.ac.uk

The DSM and ICD diagnostic systems describe "borderline personality disorder (BPD)" or "emotionally unstable personality disorder" as characterised by difficulties in emotion regulation, difficulties in interpersonal functioning (intense and unstable interpersonal relationships, hypersensitivity to rejection and abandonment), difficulties in self-perception (feelings of emptiness, dissociation or psychotic experiences, and unstable self-identity), and maladaptive regulation strategies (self-injury, suicidality, substance misuse) (APA, 2013; Oltmans et al,. 2019). Its conceptualisation as a disorder of "personality" is contentious, with some arguing it is better conceptualised as a mood disorder or as a developmental response to complex interpersonal trauma (Giourou et al., 2018; Olive, 2019; Tyrer, 2009). Others have argued that the diagnosis itself is not a real entity, but rather a social construct used to explain valid coping strategies used to survive oppression and abuse, particularly applied to women whose behaviour is viewed as violating social norms (Shaw & Proctor, 2005). Despite acknowledging the problems with the diagnosis, a recent multidisciplinary consortium including people with lived experience of the diagnosis was unable to agree on an alternative name (Personality Disorder Consensus Group (2018). In the absence of an agreed alternative, the present paper therefore uses "BPD" to encapsulate the set of experiences and behaviour described under this name in the DSM and ICD definitions, whilst also acknowledging the problems with it use, rejecting its use to pathologise survivors of trauma, and emphasising the vital importance of compassionate, trauma-informed, and formulation-led ways of working.

Much previous work has evaluated the evidence base for psychological interventions for BPD (Cristea et al., 2017; Oud et al., 2018), yet to our knowledge there have been no previous reviews evaluating which patients are currently unable to benefit from such interventions when they are implemented in practice. A recent position statement on personality disorder from the Royal College of Psychiatrists (2019) outlined ongoing difficulties in accessing and engaging with psychological interventions in the UK, and suggested a tiered approach to

service provision based on severity. However, this paper did not review the relevant literature on what factors explain difficulties in accessing psychological interventions, nor the evidence base for tiered service provision with interventions delivered at different levels of intensity, nor the evidence base for why psychological interventions fail or how treatment failure should be managed. Using the Royal College of Psychiatrists position statement (2019) as a framework, this article aims to provide an analysis of access to evidence-based psychological interventions (EBPIs) for people diagnosed with BPD in the United Kingdom, with a particular focus on identifying gaps in service provision, reviewing existing findings and presenting new data on treatment failure, and exploring possible solutions.

A History of Exclusion

BPD is one of the most heavily stigmatised diagnoses within health services (Nehls, 2000; Sheehan et al., 2016). Mental health professionals may view people with this diagnosis as manipulative, attention-seeking and difficult, and see the condition as untreatable and underserving of care (Ociskova et al., 2017). In 2003, the National Institute for Mental Health in England recognised that these attitudes have led to people being neither offered appropriate care from general mental health services nor able to access specialist evidence-based treatment for their difficulties (NIMHE, 2003). Similar concerns have been identified internationally (Mental Health Council of Australia, 2005). There is some evidence that generic psychodynamic or cognitive behaviour therapies may be minimally effective for people with BPD (Feske et al., 1996; Mennin & Heimberg, 2000; Newton-Howes et al., 2006; Perry & Cooper, 1985; Rossiter et al., 1993; Seivewright et al., 1998; Stone, 1990; Tucker et al., 1987). It has been suggested that both insight-focussed and CBT approaches can be unhelpful or even iatrogenic because they are too emotionally arousing — in the case of insight-focussed approaches by making deep and complex links between the relationship with the therapist and the patient's experience of relationships with past caregivers (Fonagy

et al., 2015), or in the case of CBT, by labelling patients' beliefs about themselves and others as dysfunctional (Linehan, 1993). These interventions applied in isolation — in the absence of techniques to reduce arousal, such as emotional validation — are argued to lead to emotional over-arousal and overwhelm, preventing therapeutic progress, generating ruptures in the therapeutic alliance, and leading to poor outcomes and treatment dropout.

Evidence-based Psychological Interventions (EBPIs) for BPD

From the early 1990s onwards, clinical academics developed new specialised treatment models for BPD, based on specific theories about the core difficulties underlying the BPD syndrome and the specific techniques required to ameliorate them. The present article will focus on DBT and MBT as these are the two models tested in the largest number of randomised controlled trials (RCTs) (3 RCTs of MBT and 13 of DBT, Oud et al., 2018) and used most commonly in the UK (Dale et al., 2017). Meta-analysis suggests that DBT and MBT improve specific aspects of BPD such as self-harm but their effect on overall BPD severity has rarely been studied and is in general not supported by the evidence (Cristea et al., 2017; Oud et al., 2018). Both are long-term approaches involving twelve to eighteen months of weekly individual and group therapy. In the DBT model, BPD develops from a transaction between biologically-based difficulties with emotion regulation that are compounded by experiences of emotionally invalidating caregiving (Linehan, 1993). DBT arose from cognitive behavioural approaches but has been specifically tailored for BPD by incorporation of validation strategies, mindfulness, and a focus on building emotion regulation capacity. In group skills training sessions patients learn mindfulness, emotion regulation, distress tolerance and interpersonal effectiveness techniques; individual therapists validate patients' emotions and behaviour whilst reinforcing implementation of the skills (Feigenbaum, 2007). MBT arose within the psychodynamic tradition and is based on the theory that — often due to disrupted caregiving experiences — the core disturbance in BPD is difficulty with

mentalizing (i.e. reflecting coherently on the mental states of oneself and others) (Fonagy & Luyten, 2009). Consequently, therapy aims to foster mentalization in interpersonal contexts (Bateman & Fonagy, 2006). Individual therapists, group therapists and other group members encourage patients to describe their own emotions, thoughts and behaviour and to be curious and open-minded about the thoughts and emotions that may underlie other people's behaviour (Fonagy et al., 2015). Importantly, both DBT and MBT aim to avoid iatrogenesis by maintaining a strong focus on understanding and validating patients' emotional experiences, particularly in situations where a patient is emotionally aroused, before attempting to promote changes in the way the person thinks, feels or behaves (Linehan, 1993; Fonagy et al., 2015).

Increasing Access to EBPIs

In the UK, practice guidelines now advocate that people with BPD should be able to access EBPIs such as DBT and MBT (UK Personality Disorder Consensus Group, 2018; Royal College of Psychiatrists, 2019), preferably through dedicated multidisciplinary services (NICE, 2009; NIMHE, 2003). In line with this, the availability of dedicated PD services has improved dramatically in the past 15 years (Dale et al., 2017). Whilst a 2002 survey revealed that only 17% of NHS Trusts had a dedicated PD service, this had risen to 84% by 2015, representing a fivefold increase (Dale et al., 2017; NIMHE, 2003). Within dedicated services, the most commonly offered EBPIs for people with PD are DBT (offered by 49% of services) and MBT (offered by 43% of services) (Dale et al., 2017).

Ongoing Exclusion: Too Well to be Treated

However, for some patients, difficulties in accessing EBPIs remain. NICE guidance specifies that specialist PD services should be provided for people with particularly complex needs or high levels of risk to self or others (NICE, 2009). Yet, it is estimated that up to one third of

people with BPD do not engage in self-harm (Soloff et al., 1994), and within those that do, many may engage mostly in superficial self-harm not deemed to present a high risk of lethality (Linehan et al., 2006; Maddock et al. 2010). Furthermore, at least two-thirds do not engage in any form of physical aggression towards others (Gonzalez et al., 2016), and the implication of a common association between BPD and violence may be part of the ongoing stigmatisation of people with this diagnosis (Nestor, 2002).The remainder of people with BPD, who present with less severe risk to self or others, may thus be excluded from accessing the EBPIs offered in dedicated services, despite experiencing significant distress and impairment in functioning.

A possible solution is offered by the UK Royal College of Psychiatrists recommendation for a stepped care model, whereby patients with the least severe levels of PD are offered low-intensity and short-term psychosocial interventions in primary care and the voluntary sector (Tier 1), patients requiring more input are offered EBPIs in generic community mental health or psychological therapy services (Tier 2), and only patients not successfully engaged or treated by Tier 2 and with a high level of risk and/or disability are offered longer-term EBPIs in dedicated PD services (Tier 3) (Royal College of Psychiatrists 2019).

Low-intensity and short-term psychological interventions

The Royal College recommendation to provide short-term interventions is contrary to NICE Guidance, which stipulates that interventions for BPD should be long-term (NICE 2009). In line with this, self-reported personality difficulties are associated with poorer outcomes from short-term treatment by primary care Improving Access to Psychological Therapies (IAPT) services (Goddard et al., 2015). IAPT professionals describe feeling deskilled in being able to help these patients (Lamph et al., 2019). Responding to this need, between 2012 and 2015 three IAPT SMI PD demonstration sites were set up. One of these was situated within

primary care services, and offered education of the workforce, guided formulation, a DBT-informed emotional skills group, and cognitive analytic therapy. The majority of patients accessing this service said they were satisfied with how therapy was provided (86%) and felt understood by their therapist (81%); 44% felt helped a lot; and 18% felt somewhat helped (Hann et al., 2015). Another low-intensity intervention developed specifically for PD is Structured Psychological Support (SPS) which draws on techniques from both DBT and MBT, delivered over 6 to 10 individual sessions plus telephone support (Crawford et al., 2018). A feasibility trial generated preliminary evidence that this approach is more effective than usual treatment for improving mental wellbeing and social adjustment (Crawford et al., 2020).

Streamlined versions of EBPIs in generic services

For those who do not benefit from low-intensity interventions or who present with increasing levels of distress or risk, the Royal College of Psychiatrists suggest that EBPIs should be provided by generic services such as community mental health teams (Royal College of Psychiatrists, 2019). In line with this, 57% of organisations surveyed in 2015 claimed to offer DBT through generic services, and 51% claimed the same for MBT. However, the quality of treatment delivery and fidelity to the treatment models could not be discerned from the survey (Dale et al., 2017). The full DBT and MBT programmes incorporate twelve to eighteen months of weekly individual and group therapy, in addition to weekly team consultation and telephone skills coaching in DBT (Bateman & Fonagy, 2006; Linehan, 1993). Generic services may lack the resources and team structure to implement the programme in full and indeed DBT implementation efforts are more likely to fail when staff have only small amounts of their time allocated to deliver it within the context of their wider role (Choi-Kain et al., 2017; Swales et al., 2012). However, evidence is increasingly emerging for the effectiveness of streamlined versions of DBT and MBT which are more

readily implemented in generic services (Choi-Kain et al., 2017). Patients' implementation of the behavioural and cognitive skills taught during DBT has been shown to promote positive outcomes (Barnicot et al., 2016; Neasciu et al., 2010). In line with this, it has been shown that implementing a DBT skills group over twelve months in addition to weekly case management is as effective as the full DBT programme for improving self-harm, suicidality, anxiety, depression, and crisis service use (Linehan et al., 2015). Structured clinical management (SCM) is another approach increasingly being advocated as being able to meet the needs of the majority of people with BPD in generic services (Anna Freud Centre, 2016; Bateman & Krawitz, 2013). SCM was developed based on expert consensus about what works best for treating BPD, and involves a structured approach including psychoeducation, alliance-building and safety planning (Bateman & Fonagy, 2009). It was devised by the developers of MBT and employs many of the same underlying therapeutic principles, including authenticity and openness, a "not knowing" stance, a focus on misunderstandings in the relationship, and curiosity about beliefs and intentions (Choi-Kain et al., 2017). In an RCT, both patients receiving 18 months of MBT and those receiving 18 months of SCM showed improvements in self-harm, suicide attempts, depression, and interpersonal functioning, and patients receiving SPM showed a faster reduction in self-harm in the first 6 months (Bateman & Fonagy, 2009). However, the authors stress that SPM cannot replace specialist psychotherapy models such as DBT and MBT, particularly for those with the most severe manifestations of BPD (Bateman & Fonagy, 2009). In this author's view caution is warranted as outcomes were in general poorer following SPM than following MBT (Bateman & Fonagy, 2009), and the outcomes of SPM have never been tested relative to usual treatment. Furthermore, it is also important to note that neither DBT skills groups nor SCM should be implemented by sole practitioners; indeed doing so may increase the potential for iatrogenesis (Bateman & Tyrer, 2004). Rather, it is vital that both models are implemented by

a team of trained practitioners who meet together regularly for supervision, during which establishing a common understanding of cases, support for therapist burnout, and reflection on difficulties in the therapeutic alliance or impediments to therapeutic progress, should be central (Bateman & Krawitz, 2013; Linehan, 1993; Linehan et al., 2015; NICE, 2015). Despite this, an implementation survey in the USA found that DBT is often implemented in routine settings without regular team consultation, and lack of a consistent and coherent team structure was one of the most frequently cited barriers to successful implementation (Landes et al., 2017).

Ongoing Exclusion: Too Unwell to be Treated

Patients who do not benefit from streamlined EBPIs in generic services, or who present with higher severity or risk, can be stepped up to twelve to eighteen-month DBT, MBT or other EBPIs, preferably implemented by dedicated PD services (Royal College of Psychiatrists, 2019). However, over half of dedicated services exclude patients with substance misuse problems (Dale et al., 2017) — despite the fact that difficulties with self-damaging impulsive behaviour, often including substance misuse, are one of the diagnostic criteria for BPD (APA, 2013), and in one study of inpatients with BPD, over 60% reported difficulties with substance misuse (Zanarini et al, 2004). Many services also exclude on the basis of risk to others, risk to self or comorbid psychotic disorder (Dale et al. 2017). Services should not exclude on the basis of these difficulties unless they present with such severity that they cannot be safely managed. Where possible, adaptations should be made to cater for the additional needs of people with these difficulties. For instance, DBT has been adapted to help women with BPD and comorbid substance dependence (Linehan et al., 2002).

Remaining Gaps: People who Discontinue or Do Not Benefit from Long-Term EBPIs

However, this still leaves an important gap in both the evidence base and service provision for patients who are offered twelve to eighteen month EBPIs but who discontinue or are left with significant problems even after completing. As can be seen in Table 1 and Table 2, the average degree of improvement following DBT or MBT is impressive. Nonetheless, this still leaves patients contending with on average 3 to 4 of the difficulties associated with the diagnosis of BPD, with 30% still meeting diagnostic criteria (Koons et al., 2001), and with a quarter still engaging in severe self-harm (Bateman & Fonagy, 2009). Long-term follow-up shows that 5 years after the end of MBT, patients continue to show markedly lower rates of suicide attempts, service use and psychiatric medication use than those who received usual treatment alone, but nonetheless 23% did attempt suicide at least once, and their general social and occupational functioning remained impaired (Bateman & Fonagy, 2008).

Where limited difficulties remain, step-down to a generic approach such as GPM may be appropriate (Bateman & Fonagy 2009). But for those with significant remaining difficulties, the evidence base for what to do next is non-existent. EBPIs such as DBT and MBT have specifically been designed to prevent iatrogenesis (Fonagy & Bateman, 2006; Linehan, 1993). However, detailed analysis of data from two studies suggests that 18 to 24% of patients actually show an increase in the frequency of self-harm, and 33% show an increase in observer-rated or self-rated BPD severity following DBT or MBT delivered in UK specialist PD services (data from Barnicot & Crawford, 2019; Priebe et al., 2012). Worsening was more likely amongst people who discontinued treatment prematurely (29 to 36% for self-harm and 47 to 50% for BPD severity) than those who completed (5 to 14% for self-harm and 21 to 24% for BPD severity). Rates of worsening while receiving non-specialist "treatment as usual" were higher than those following completion of DBT or MBT but lower than those following premature discontinuation, with 23% exhibiting an increase in self-harm and 35%

exhibiting an increase in BPD severity (data from Priebe et al., 2012). This highlights a potentially iatrogenic consequence of premature treatment discontinuation. Whilst a portion of those who experienced worsening following an EBPI may have been those who would have deteriorated anyway regardless of the treatment offered, it is clear that there are a substantial proportion of patients for whom EBPIs are not conferring any measurable benefit on key outcomes.

What treatment options should be available for this group of patients? Clearly neither step-down to a streamlined version of the same EBPI, nor step-up to Tier 4 residential treatment, would be appropriate for the vast majority. It is helpful to consider how and why treatment discontinuation and/or treatment failure occur. Of course, worsening may have preceded and contributed to difficulties engaging with the intervention — but as well as considering how difficulties in the patient may have contributed, it is equally important to consider the role of the therapist and of other group members.

Difficulties in the therapeutic alliance and epistemic hypervigilance

A negative experience of the therapeutic alliance is one of the most consistent predictors of treatment discontinuation and poor outcome in BPD (Barnicot et al., 2011; Barnicot et al., 2012). A problematic therapeutic alliance may be particularly re-traumatising and hence iatrogenic for patients with a history of severe relational trauma. The developers of MBT contend that treatment failure can often be attributed to a single underlying mechanism: the failure of the treatment to establish and maintain "epistemic trust" in the patient (Fonagy & Allison, 2014). This concept refers to a person's willingness to consider new knowledge from another person as trustworthy, generalizable, and relevant to the self. This willingness is crucial to enable learning in and from social situations, including the social situation of a

therapy session. The converse is “epistemic mistrust” or “epistemic hypervigilance”. This occurs as the result of disrupted or traumatic caregiving experiences in childhood whereby the child learns not to trust in the validity of their own experience or of information communicated by others. The resultant continual uncertainty (or rigidity) makes it very difficult for a person to learn the new ways of thinking, feeling and understanding themselves or others that therapy aims to “teach”. Successful therapy will overcome these barriers by making the patient feel that their experiences are understandable and understood: by providing a theoretical framework with which to understand the patient’s difficulties, and by showing an understanding of patients’ emotions, thoughts and behaviour through the processes of mentalizing (or the related process of validation in DBT). In turn, the therapist will help the patient to better understand their social world external to therapy, facilitating the patient to engage with other people in more positive and open ways that allow the possibility of feeling understood by others, and thereby generating a new openness to gaining new learning about themselves and others. By contrast, when therapy fails, Fonagy and Allison (2014) contend that either the therapist has failed to convince the patient that they are understood and hence epistemic hypervigilance has remained high and has disrupted therapeutic learning — or the patient’s social world has remained so hostile and re-traumatising that the patient is not able to gain new experiences of feeling understood by others. A further factor is that the patient’s epistemic hypervigilance and/or not feeling understood by group members may have disrupted their ability to learn during group sessions. Whilst many patients receiving either DBT or MBT initially find the group sessions anxiety-provoking, if patients’ anxieties during the therapy group do not habituate this has been linked to both treatment dropout and poor treatment outcome (Barnicot et al., 2015; Barnicot et al., in prep.). A systematic review of qualitative interviews with DBT patients highlighted that the group element of therapy is often experienced as overwhelming (Little et

al., 2017), whilst patients in Lonargáin and colleagues' (2017) qualitative interview study described the MBT group as an unpredictable and challenging place where they felt unsafe. Sagen and Karterud's analysis of video data from MBT group sessions (2014) sheds some light on how these difficulties can arise, with therapists failing to take an authoritative leadership role or to structure the session in such a way as to optimally promote mentalizing, leading to sessions dominated by disturbing accounts from a few members and characterised by pseudomentalization.

Difficulties in therapist adherence to the treatment model

The DBT manual is very clear that treatment failures should never be attributed to the patient — instead, failure is always attributed either to the therapist or to the model itself (Linehan, 1993). It is the role of the therapist to enhance the patient's motivation to attend treatment and failure may occur when the therapist does not do this sufficiently, or when the therapist engages in other "therapy-interfering" behaviours. For example, in a case study a DBT therapist theorises that her own failure to fully adhere to the DBT model may have led to a poor treatment outcome (Rizvi, 2011). In particular, she attributes the poor outcome to her de-prioritising dealing with the patient's self-harm and therapy-interfering behaviours, her inadvertent reinforcement of the patient's therapy-interfering behaviour, and her avoidance during team consultation sessions of discussing the difficulties she was encountering. These behaviours in turn were driven by fear — fear of the patient committing suicide, and fear of being negatively evaluated by colleagues.

Selection of patients and rules for attendance

In an evaluation of six UK personality disorder services offering twelve to eighteen months of DBT or MBT, treatment retention rates at twelve months were substantially higher amongst patients offered MBT (72% retention) than those offered DBT (42% retention)

(Barnicot & Crawford, 2019). Evaluations of other efforts to implement MBT in routine settings outside of the treatment development centre have also published high treatment completion rates — 72% in a Danish programme and 98% in a Norwegian programme (Jorgensen et al., 2013; Kvarstein et al., 2014). By contrast, completion rates for DBT are generally lower when it is implemented in routine services than when implemented by the treatment provider (Landes et al., 2016), and seem particularly low in UK specialist PD services (e.g. 42%, Barnicot & Crawford, 2019; 42%, Feigenbaum et al., 2012; 48%, Priebe et al., 2012).Thus, when implemented in routine settings, more patients seem to discontinue DBT than MBT. One contributing factor could be that in many MBT programmes, only patients who attend a preliminary 10-week group programme, indicate their interest in further group-based treatment, and are judged by staff to have the potential to benefit are able to begin the full MBT programme (Barnicot & Crawford, 2019). MBT patients may therefore already be selected as individuals with both the practical and emotional capability to sustain the commitment of attending treatment, whereas DBT patients may be a less selected group of individuals who vary more widely in their capabilities to commit. Another factor could be that DBT arguably prescribes a less flexible approach to treatment non-attendance, whereby if 4 or more consecutive sessions of either group or individual treatment are missed, treatment is terminated (Linehan, 1993). The aim of this is to shape behaviour by providing a negative reinforcer for missing sessions. Conversely, the MBT manual does not specify a numerical rule for the number of missed sessions leading to treatment termination — instead, decisions about treatment termination are made on an individualised basis following a team case discussion.

The pain of treatment discontinuation or failure

For people with a history of severe relational trauma, the experience of being told that treatment has been terminated may in itself be re-traumatising, and the particular experience of feeling they have "failed" an evidence-based intervention may contribute to an increased sense of hopelessness and low self-esteem.

What to do following EBPI discontinuation or failure

Where treatment discontinuation or poor outcome has occurred, a long-term lead clinician external to the EBPI should remain in place (Royal College of Psychiatrists, 2019), one of whose roles will be to meet with both the patient and the EBPI team to try to understand what went wrong. It is vital here to listen to the patient's point of view and to validate their understanding of what happened. Consider how the patient's difficulties may have contributed but also reflect on the therapist's role in failing to establish epistemic trust and any other "therapy-interfering" behaviour. For patients for whom the group therapy context has been particularly difficult, consider that individual therapy alone — such as schema therapy or individual DBT — may be a better fit for this particular patient (although individual-only DBT is associated with poorer outcomes overall, Linehan et al., 2015). NICE guidance stipulates that specialist PD services should offer a range of EBPIs and the patient should be able to choose between them (NICE, 2015). Whether this happens in practice or is feasible in resource-limited services remains to be seen.

Thoughts for the Future — Increasing Access to Trauma-Focussed EBPIs

One factor that has been proposed to limit treatment success with EBPIs is the presence of comorbid post-traumatic stress disorder (PTSD). Patients with BPD report high levels of childhood emotional, sexual and physical abuse, often in addition to ongoing relational trauma in adulthood (Golier et al., 2003; Zanarini et al., 1997). Indeed, some argue that BPD

should be reconceptualised as a developmental response to the experience of complex interpersonal trauma (Driessen et al., 2002). Comorbid PTSD, greater severity of PTSD symptoms or failure to improve PTSD during treatment have each been associated with less improvement in self-harm and BPD symptoms following DBT or MBT (Barnicot & Crawford, 2018; Barnicot & Priebe, 2013; Harned et al. 2010). Meta-analysis has shown that the most effective treatments for PTSD include an element of re-exposure to traumatic experiences (Bisson et al., 2007). Yet patients with BPD — or with problems associated with BPD such as self-harm and suicidality — are often excluded from trauma-focussed treatments, due to fears of iatrogenesis (Harned et al., 2014). These fears are beginning to be disproved as trials in the USA and in Germany have shown that combining DBT with trauma-focussed treatments is not only safe, but highly effective, leading to impressive reductions in PTSD symptoms, self-harm, and emotional dysregulation (Bohus et al., 2013; Harned et al. 2014). Others have shown that even without the inclusion of a "stabilising" treatment such as DBT, trauma-focussed treatments such as eye movement desensitization reprocessing (EMDR) can be both safe and effective — although one of these trials excluded patients with a recent history of suicide attempts (De Jongh et al., 2020; Slotema et al., 2019). However, in a recent national survey of dedicated and generic services for PD in the UK, no services reported offering trauma-focussed therapies (Dale et al., 2017), and access to treatments for PTSD does not form any part of current clinical recommendations for the treatment of BPD (NICE, 2009; NIMHE, 2003; Royal College of Psychiatrists, 2019). This picture may slowly be beginning to change with the availability of training in DBT with prolonged exposure (British Isles DBT Training, 2020). Furthermore, with the addition of complex PTSD to ICD-11 — a condition which shares many features with BPD such as affect dysregulation and interpersonal dysfunction (WHO, 2018) — some patients currently

diagnosed with BPD may be re-diagnosed, opening the door to access to trauma-focussed treatments in line with recommendations for the treatment of complex PTSD (NICE, 2018).

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (5th ed.).* Washington, DC: American Psychiatric Association.

Anna Freud Centre (2016). *Structured Clinical Management Commissioner Guidance Document.* From https://www.annafreud.org/media/4298/scm-commissioner-guidance-document.pdf

Bandelow, B., Krause, J., Wedekind, D., Broocks, A., Hajak, G., &Ruther, E. (2005). Early traumatic life events, parental attitudes, family history and birth risk factors in patients with borderline personality disorder and healthy controls. *Psychiatry Research*, *134*: 169–179.

Barnicot, K., Bhatti, N., Savill, M., & Priebe, S. (2014). A pragmatic randomised controlled trial of dialectical behaviour therapy: effects on hospitalisation and post-treatment follow-up. *Psychotherapy and Psychosomatics*, *83*: 192–193.

Barnicot, K., Couldrey, L., Sandhu, S., & Priebe, S. (2015). Overcoming barriers to skills training in borderline personality disorder: a qualitative interview study. *PLoS ONE, 10(10): e0140635.*

Barnicot, K., & Crawford, M. (2018). Post-traumatic stress disorder in patients with borderline personality disorder: treatment outcomes and mediators. *Journal of Traumatic Stress*, *31(6):*899–908.

Barnicot, K., & Crawford, M. (2019). Dialectical behaviour therapy v. mentalisation-based therapy for borderline personality disorder. *Psychological Medicine*, *49(12):* 2060–2068.

Barnicot, K., Gonzalez, R., McCabe, R., & Priebe, S. (2016). Skills use and common treatment processes in dialectical behaviour therapy for borderline personality disorder. *Journal of Behaviour Therapy and Experimental Psychiatry*, *52*:147–156.

Barnicot, K., Katsakou, C., Bhatti, N., Savill, M., Fearns, N., & Priebe, S. (2012). Factors predicting the outcome of psychotherapy for borderline personality disorder: a systematic review. *Clinical Psychology Review, 32(1):* 400–412.

Barnicot, K., Katsakou, C., Marougka, C., & Priebe, S. (2011). Treatment completion in psychotherapy for borderline personality disorder: a systematic review and meta-analysis. *Acta Psychiatrica Scandinavica, 123(5)*: 327–338.

Barnicot,K., & Priebe, S. (2013). Posttraumatic stress disorder and the outcome of dialectical behavior therapy for borderline personality disorder. *Personality and Mental Health, 7*: 181–190.

Barnicot, K., Redknapp, C., Coath, F., Hommel, J., Couldrey, L., & Crawford, M. (in prep.). Patient experiences of therapy for borderline personality disorder: commonalities and differences between dialectical behaviour therapy and mentalization based therapy and relation to outcomes.

Bateman, A. & Fonagy, P. (2006) *Mentalization-Based Treatment for Borderline Personality Disorder: A Practical Guide.* Oxford: Oxford University Press.

Bateman, A., & Fonagy, P. (2008). 8-year follow-up of patients treated for borderline personality disorder: mentalization-based treatment versus treatment as usual. *American Journal of Psychiatry, 165(5)*: 631–638.

Bateman, A. & Fonagy, P. (2009) Randomized controlled trial of outpatient mentalization based treatment versus structured clinical management for borderline personality disorder. *American Journal of Psychiatry, 166*: 1355–1364.

Bateman, A., & Krawitz, R. (2013) *Borderline Personality Disorder: An Evidence-Based Guide for Generalist Mental Health Professionals.* Oxford: Oxford University Press.

Bateman, A., & Tyrer, P. (2004). Services for personality disorder: organisation for inclusion. *Advances in Psychiatric Treatment, 10:* 425–433.

Bisson, J.I., Ehlers, A., Matthews, R., Pilling, S. Richards, D., & Turner, S. (2007). Psychological treatments for chronic post-traumatic stress disorder: Systematic review and meta-analysis. *British Journal of Psychiatry, 190:* 97–104.

Bohus, M., Dyer, A. S., Priebe, K., Kruger, A., Kleindienst, N., Schmahl, C., Niedtfeld, I., & Steil, R. (2013). Dialectical behavior therapy for post-traumatic stress disorder after childhood sexual abuse in patients with and without borderline personality disorder: A randomised controlled trial. *Psychotherapy and Psychosomatics, 8*, 221–233.

British Isles DBT Training (2020). *Intensive Training in the DBT Prolonged Exposure Protocol for PTSD: 4 Day Intensive Workshop*. From https://www.dbt-training.co.uk/course/intensive-training-in-the-dbt-prolonged-exposure-protocol-ptsd-4-day-intensive-workshop-2020/

Choi-Kain, L.W., Finch, E.F., Masland, S.R., Jenkins, J.A., & Unruh, B. (2017). What works in the treatment of borderline personality disorder. *Current Behavioral Neuroscience Reports, 4(1)*: 21–30.

Crawford, M.J., Thana, L., Parker, J., Turner, O., Pei Xing, K., McMurran, M., Moran, P., Weaver, T., Barrett, B., Claringbold, A., Bassett, P., Sanatinia, R. (2018). Psychological Support for Personality (PSP) versus treatment-as-usual: study protocol for a feasibility randomised controlled trial of a low intensity intervention for people with personality disorder. *Trials, 19*: 547.

Crawford, M.J., Thana, L., & Sanatinia, R. (2020). Structured psychological support (SPS) for people with personality disorder: feasibility randomised controlled trial of a low-intensity intervention. *British Journal of Psychiatry Open* (in press).

Cristea, I.A., Gentili, C., Cotet, C.D., Palomba, D., Barbui, C., & Cuijpers, P. (2017). Efficacy of psychotherapies for borderline personality disorder: a systematic review and meta-analysis. *Journal of American Medical Association Psychiatry, 74:* 319–328.

Dale, O., Sethi, F., Stanton, C., Evans, S., Barnicot, K., Sedgwick, R., Goldsack, S., Doran, M., Shoolbred, L., Samele, C., Urquia, N., Haigh, R., & Moran, P. (2017). Personality disorder services in England: findings from a national survey. *British Journal of Psychiatry Bulletin*, *41(5):*247–253.

Department of Health (2014). *Meeting the Challenge: Making a Difference. Working Effectively to Support People with Personality Disorder in the Community.* From http://repository.tavistockandportman.ac.uk/864/

De Jongh, A., Groenland, G. N., Sanches, S., Bongaerts, H., Voorendonk, E. M., & Van Minnen, A. (2020) The impact of brief intensive trauma-focused treatment for PTSD on symptoms of borderline personality disorder. *European Journal of Psychotraumatology*, 11:1.

Driessen, M., Beblo, T., Reddemann, L., Rau, H., Lange, W., Silva, A., & Ratzka, S. (2002). Is the borderline personality disorder a complex post-traumatic stress disorder? The state of research. Review. *Nervenarzt*, *73(9):*820–829.

Feigenbaum, J.D. (2007). Dialectical behaviour therapy: an increasing evidence base. *Journal of Mental Health, 16(1)*: 51 – 68.

Feigenbaum, J.D., Fonagy, P., Pilling, S., Jones, A., Wildgoose, A., & Bebbington, P.E. (2012) A real-world study of the effectiveness of DBT in the UK National Health Service. *British Journal of Clinical Psychology*, *51:*121–141.

Feske, U., Perry, K.J., Chambless, D.L., Renneberg, B., & Goldstein, A.J. (1996). Avoidant personality disorder as a predictor for treatment outcome among generalised social phobics. *Journal of Personality Disorders, 10(2):* 174–184.

Fonagy, P., & Allison, E. (2014). The Role of Mentalizing and Epistemic Trust in the Therapeutic Relationship. *Psychotherapy, 51(3):* 372–380.

Fonagy, P., & Bateman, A. (2006). Progress in the treatment of borderline personality disorder. *British Journal of Psychiatry, 188*: 1–3.

Fonagy, P., & Luyten, P. (2009). A developmental, mentalization-based approach to the understanding and treatment of borderline personality disorder. *Development and Psychopathology, 21:* 1355–1381.

Fonagy, P., Luyten, P., & Bateman, A. (2015). Translation: Mentalizing as treatment target in borderline personality disorder. *Personality Disorders, 6(4):* 380–92.

Fonagy, P., Luyten, P., Allison, E., & Campbell, C. (2017). What we have changed our minds about: Part 2. Borderline personality disorder, epistemic trust and the developmental significance of social communication. *Borderline Personality Disorder and Emotion Dysregulation, 4*: 9

Giourou, E., Skokou, M., Andrew, S.P., Alexopoulou, K., Gourzis, P., & Jelastopulu, E. (2018). Complex posttraumatic stress disorder: the need to consolidate a distinct clinical syndrome or to re-evaluate features of psychiatric disorders following interpersonal trauma? *World Journal of Psychiatry, 8(1):* 12–19.

Goin, M.K. (1998). Borderline personality disorder: splitting countertransference. *Psychiatric Times, 15:*11.

González, R.A., Igoumenou, A., Kallis, C., & Coid, J.W. (2016). Borderline personality disorder and violence in the UK population: categorical and dimensional trait assessment. *BMC Psychiatry, 16*:180

Fonagy, P., & Bateman, A. (2006). Progress in the treatment of borderline personality disorder. *The British Journal of Psychiatry, 188(1):* 1–3.

Goddard, E., Wingrove, J., Moran, P. (2015). The impact of comorbid personality difficulties on response to IAPT treatment for depression and anxiety. *Behaviour Research and Therapy, 73:* 1–7.

Golier, J. A., Yehuda, R., Bierer, L. M., Mitropoulu, V., New, A. S., Schmeidler, J., Silverman, J.M., & Siever, L. J. (2003). The relationship of borderline personality disorder to post traumatic stress disorder and traumatic events. *The American Journal of Psychiatry, 160*: 2018–2014.

Jorgensen, C.R., Freund, C., Boye, R., Jordet, H., Andersen, D., & Kjølbye, M. (2013) Outcome of mentalization-based and supportive psychotherapy in patients with borderline personality disorder: a randomized trial. *Acta Psychiatrica Scandinavica, 127:* 305–317

Kealy, D., Ogrodniczuk, J.S. (2010). Marginalization of borderline personality disorder. *Journal of Psychiatric Practice, 16(3)*:145–54.

Koons, C.R., Robins, C.J., Tweed, J.L., Lynch, T.R., Gonzalez, A.M., Morse, J.Q., Bishop, G.K., Butterfield, M.I., & Bastian, L.A. (2001). Efficacy of dialectical behavior therapy in women veterans with borderline personality disorder. *Behaviour Therapy, 32*: 371–390.

Hann, A., Hemming, L., Billsborough, J., Couperthwaite, L., Hewis, E., Pinfold, V., & Hamilton, S. (2015). A service user evaluation of the IAPT for SMI demonstration sites. From: https://mcpin.org/wp-content/uploads/Full-report-from-service-user-evaluation-of-IAPT-for-SMI.pdf

Harned, M. S., Rizvi, S. L., & Linehan, M. M. (2010). Impact of co-occurring post-traumatic stress disorder on suicidal women with borderline personality disorder. *The American Journal of Psychiatry, 167*: 1210–1217.

Harned, M. S., Korslund, K., & Linehan, M. M. (2014). A pilot randomized controlled trial of dialectical behavior therapy with and without the dialectical behavior therapy prolonged exposure protocol for suicidal and self-injuring women with borderline personality disorder and PTSD. *Behavior Research and Therapy, 55*, 7–17.

Kvarstein, E.H., Pedersen, G., Urnes, Ø., Hummelen, B., Wilberg, T. & Karterud, S. (2015), Changing from a traditional psychodynamic treatment programme to mentalization-based

treatment for patients with borderline personality disorder – Does it make a difference?. *Psychology and Psychotherapy Theory Research and Practice, 88*: 71–86.

Lambert, M.J. (2013). The efficacy and effectiveness of psychotherapy. In: MJ Lambert (Ed.), *Handbook of Psychotherapy and Behavior Change (6th edn.)* (pp. 169–218). London: Wiley.

Lamph, G., Baker, J., Dickinson, T., & Lovell, K. (2019) Personality disorder co-morbidity in primary care 'Improving Access to Psychological Therapy' services: a qualitative study exploring professionals' perspectives of working with this patient group. *Personality and Mental Health*, 13: 168–179.

Landes, S.J., Chalker, S.A., & Comtois, K.A. (2016) Predicting dropout in outpatient dialectical behaviour therapy with patients with borderline personality disorder receiving psychiatric disability. *Borderline Personality Disorder and Emotional Dysregulation, 3:* 9.

Landes, S.J., Rodriguez, A.L., Smith, B.N., Matthieu, M.M., Trent, L.R., Kemp, J., &Thompson, C. (2017). Barriers, facilitators, and benefits of implementation of dialectical behavior therapy in routine care: results from a national program evaluation survey in the Veterans Health Administration. *Translational Behavioral Medicine, 7*:832–844.

Linehan, M.M. (1993). Cognitive-Behavioral Treatment of Borderline Personality Disorder. New York: Guildford Press.

Linehan, M.M., Armstrong, H.E., Suarez, A., Allmon, D., & Heard, H.L. (1991) Cognitive-behavioral treatment of chronically para-suicidal borderline patients. *Archives of General Psychiatry, 48*: 1060–1064.

Linehan, M.M., Comtois, K.A., Brown, M.Z., Heard, H.L., & Wagner, A. (2006a). Suicide attempt self-injury interview (SASII): development, reliability, and validity of a scale to assess suicide attempts and intentional self-injury. *Psychological Assessment, 18*: 303–312.

Linehan, M.M., Comtois, K.A., Murray, A.M., Brown, M.Z., Gallop, R.J., Heard, H.L., Korslund, K.E., Tutek, D.A., Reynolds, S.K., & Lindenboim, N. (2006b), Two-year randomized controlled trial and follow-up of dialectical behaviour therapy versus therapy by experts for suicidal behaviours and borderline personality disorder. *Archives of General Psychiatry, 63*: 757–766.

Linehan, M.M., Dimeff, L.A., Reynolds, S.K., Comtois, K.A., Welch, S.S., Heagerty, P., & Kivlahan, D.R. (2002). Dialectical behavior therapy versus comprehensive validation therapy plus 12-step for the treatment of opioid dependent women meeting criteria for borderline personality disorder. *Drug and Alcohol Dependence, 67*: 13–26.

Linehan, M.M., Korslund, K.E., Harned, M.S., Gallop, R.J., Lungu, A., Neasciu, A.D., McDavid, J., Comtois, K.A., & Murrary-Gregory, A.M. (2015). Dialectical behavior therapy for high suicide risk in individuals with bor,derline personality disorder: A randomized clinical trial and component analysis. *JAMA Psychiatry, 72(5):* 475–482.

Maddock, G.R., Carter, G.L., Murrell, E.R., Lewin, T.J., & Conrad, A.M. (2010). Distinguishing suicidal from non-suicidal deliberate self-harm events in women with borderline personality disorder. *Australian and New Zealand Journal of Psychiatry, 44*:574–582.

Little, H., Tickle, A. C., & das Nair, R. (2017). Process and impact of dialectical behaviour therapy: A systematic review of perceptions of clients with a diagnosis of borderline personality disorder. *Psychology and Psychotherapy, 91(3):* 278–301.

Lonargáin, D.O., Hodge, S., & Line, R. (2017). Service user experiences of mentalisation based treatment for borderline personality disorder. *Mental Health Review Journal, 22(1):* 16–27.

Mennin, D.S., & Heimberg, R.G. (2000). The impact of comorbid mood and personality disorders in the cognitive behavioural treatment of panic disorder. *Clinical Psychology Review, 20(3):* 339–357.

Mental Health Council of Australia (2005). *Not for Service: Experiences of Injustice and Despair in Mental Health Care in Australia*. From https://www.humanrights.gov.au/sites/default/files/content/disability_rights/notforservice/documents/NFS_Finaldoc.pdf

Neacsiu, A. D., Rizvi, S. L., & Linehan, M. M. (2010). Dialectical behavior therapy skills use as a mediator and outcome of treatment for borderline personality disorder. *Behaviour Research and Therapy, 48:* 832–839.

Nehls, N (2000). Recovering: a process of empowerment. *Advances in Nursing Science, 22(4):* 62–70.

National Institute for Mental Health in England (2003). Personality disorder: No Longer a Diagnosis of Exclusion. Policy Implementation Guidance for the Development of Services for People with Personality Disorder . From http://personalitydisorder.org.uk/wp-content/uploads/2015/04/PD-No-longer-a-diagnosis-of-exclusion.pdf

National Institute for Health and Care Excellence (NICE) (2015). *Personality Disorders: Borderline and Antisocial. Quality standard [QS88]*. From https://www.nice.org.uk/guidance/qs88

National Institute for Health and Care Excellence (2015). Support for commissioning for personality disorders: borderline and antisocial. From https://www.nice.org.uk/guidance/qs88/resources/support-for-commissioning-for-personality-disorders-borderline-and-antisocial-pdf-163451785669

National Institute for Health and Care Excellence (NICE) (2018). *Post-Traumatic Stress Disorder. NICE guideline [NG116]*. From https://www.nice.org.uk/guidance/ng116

Nestor, P. (2002). Mental Disorder and Violence: Personality Dimensions and Clinical Features. *The American Journal of Psychiatry, 159(12):* 1973–1978.

Nott, A. (2014). Understanding persons with personality disorders: intervention in occupational therapy. In: R. Crouch R & V. Alers (Eds.), Occupational Therapy in Psychiatry and Mental Health (5th Edition), pp. Chichester: John Wiley & Sons.

Newton-Howes, G., Tyrer, P., & Johnson, T. (2006). Personality disorder and the outcome of depression: meta-analysis of published studies. *The British Journal of Psychiatry, 188(1):* 13–20.

Ociskova, M., Prasko, J., Latalova, K., Sedlackova, Z., Kamaradova, D., Sandoval, A., & Grambal, A. (2017). F*ck your care if you label me! Borderline personality disorder, stigma, and self-stigma. *Activitas Nervosa Superior Rediviva, 59(1):* 16–22.

Olive, R.R. (2019) Beyond the Borderline. The Lancet Psychiatry 6(3): 187.

Oltmans, J.R., & Widiger, T.A. (2019). Evaluating the assessment of the ICD-11 personality disorder diagnostic system. *Psychological Assessment, 31(5):*674–684.

Oud, M., Arntz, A., Hermens, M.L.M., Verhoef, R., & Kendall, T. (2018) Specialized psychotherapies for adults with borderline personality disorder: A systematic review and meta-analysis. *Australian & New Zealand Journal of Psychiatry, 52(10):* 949–961.

Perry, J.C., & Cooper, S.H. (1985). Psychodynamics, symptoms, and outcome in borderline and antisocial personality disorders and bipolar type II affective disorder. In: TH McGlashan, (Ed.). The Borderline: Current Empirical Research. Washington: American Psychiatric Press, pp. 21–41.

Personality Disorder Consensus Group (2018). Shining Lights in Dark Corners of People's Lives. The Consensus Statement for People with Complex Mental Health Difficulties who are Diagnosed with a Personality Disorder. From https://www.mind.org.uk/media/21163353/consensus-statement-final.pdf

Priebe, S., Bhatti N., Barnicot, K., Bremner, S., Gaglia, A., Katsakou, C., Molosankwe, I., McCrone, P., & Zinkler, M. (2012) Effectiveness and cost effectiveness of dialectical behaviour therapy for self-harming patients with personality disorder: a pragmatic randomised controlled trial. *Psychotherapy and Psychosomatics, 81:* 356–365.

Rayner, G., Blackburn, J., Edward, K.L., Stephenson, J., & Ousey, K. (2019). Emergency department nurse's attitudes towards patients who self-harm: a meta-analysis. *International Journal of Mental Health Nursing, 28(1)*: 40–53.

Rizvi, S.L. (2011). Treatment Failure in Dialectical Behavior Therapy. *Cognitive and Behavioral Practice, 18(3):* 403–412

Rossiter, E.M., Agras, W.S., Telch, C.F., & Schneider, J.A. (1993). Cluster B personality disorder characteristics predict outcome in the treatment of bulimia nervosa. *International Journal of Eating Disorders, 13(4):* 349—357.

Royal College of Psychiatrists (2019). PS06/19 Services for People Diagnosed with Personality Disorder. From https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/position-statements/ps01_20.pdf?sfvrsn=85af7fbc_2

Sagen Inderhaug, T., & Karterud, S. (2015). A Qualitative Study of a Mentalization-based Group for Borderline Patients. *Group Analysis, 48(2):* 150–163.

Seivewright, H., Tyrer, P., & Johnson, T. (1998). Prediction of outcome in neurotic disorder: a 5-year prospective study. *Psychological Medicine, 28(5):* 1149–1157.

Shaw, C., Proctor, G. (2005). Women at the margins: A critique of the diagnosis of borderline personality disorder. Feminism & Psychology, *15(4):* 483-490.

Sheehan, L., Nieweglowski, K., & Corrigan, P. (2016). The stigma of personality disorders. *Current Psychiatry Reports, 18*: 11.

Slotema, C.W., van den Berg, D.P., Driessen, A., Wilhelmus, B., & Franken, I.H.A. (2019). Feasibility of EMDR for posttraumatic stress disorder in patients with personality disorders: A pilot study. European Journal of Psychotraumatology 10(1): 1614822.

Soloff, P.H., Lis, J.A., Kelly, T., Cornelius, J., Ulrich, R. (1994). Self-mutilation and suicidal behavior in borderline personality disorder. Journal of Personality Disorders 8(4): 257–267.

Swales, M.A., Taylor, B., & Hibbs, R.A. (2012). Implementing dialectical behaviour therapy: programme survival in routine healthcare settings. *Journal of Mental Health, 21(6):* 548–555.

Stone, M.H. (1990). The Fate of Borderline Patients: Successful Outcome and Psychiatric Practice. New York: Guilford Press.

Tucker, L., Bauer, S.F., Wagner, S.C., & Harlam, D. (1987). Long-term hospital treatment of borderline patients: a descriptive outcome study. *American Journal of Psychiatry, 144:* 1443–1448.

Tyrer, P. (2009). Why borderline personality disorder is neither borderline nor a personality disorder. *Personality, 3*: 86–95.

World Health Organisation (2018). International Classification of Diseases -11 for Mortality and Morbidity Statistics. From https://icd.who.int/browse11/l-m/en#/http%3a%2f%2fid.who.int%2ficd%2fentity%2f585833559

Zanarini, M., Frankenburg, F.R., Hennen, J., Reich, D.B., & Silk, K.R. (2004). Axis I comorbidity in patients with borderline personality disorder: 6-year follow-up and prediction of time to remission. *American Journal of Psychiatry, 161:* 2108–2114.

Zanarini, M. C., Williams, A. A., Lewis, R. E., Reich, R. B., Soledad, C. V., Marino, M. F., Levin, A., Yong, L., & Frankenburg, F. R. (1997). Reported pathological childhood experiences associated with the development of borderline personality disorder. *The American Journal of Psychiatry, 154*: 1101–1106.

Table 1. Pre- and post-treatment borderline personality disorder severity in randomised controlled trials of dialectical behaviour therapy or mentalization based therapy

Intervention	Comparator	Trial	Treatment developer or Independent centre	Measure of BPD severity	BPD severity at pre-treatment in the intervention condition Mean (sd) or N (%)	BPD severity at pre-treatment in the comparator condition Mean (sd) or N (%)	BPD severity at post-treatment in the intervention condition Mean (sd) or N (%)	BPD severity at post-treatment in the comparator condition Mean (sd) or N (%)
DBT	General psychiatric management	McMain et al. 2009	Independent centre	ZAN-BPD	15.49(6.14)	14.94(6.59)	7.93 (6.11)	8.16 (5.79)
	Treatment-as-usual	Koons et al. 2001	Independent centre	Number of SCID-II criteria	6.8(1.1)	6.7(0.8)	3.6 (1.6)	4.2 (2.3)
				Number meeting SCID-II diagnosis (5+ criteria)	10(100%)	10(100%)	3 (30%)	5 (50%)
		Priebe et al. 2012	Independent centre	ZAN-BPD	17.9(6.8)	18.4(7.6)	13.1 (6.9)	15.9 (7.5)
MBT	Supportive therapy	Jorgensen et al. 2013	Independent centre	Number of SCID-II criteria	6.7(1.2)	6.9(1.3)	2.8(2.5)	3.6(2.1)

BPD = borderline personality disorder; DBT = Dialectical behaviour therapy; MBT = Mentalization based therapy; SCID-II = Structured Clinical Interview for DSM-IV Axis II Disorders; ZAN-BPD = Zanarini Rating Scale for Borderline Personality Disorder

Table 2. Pre- and post-treatment self-harm in randomised controlled trials of dialectical behaviour therapy or mentalization based therapy

Intervention	Comparator	Trial	Treatment developer or Independent centre	Measure of self-harm	Self-harm at pre-treatment in the intervention condition Mean (sd) or n(%)	Self-harm at pre-treatment in the comparator condition Mean (sd) or n(%)	Self-harm at post-treatment in the intervention condition Mean (sd) or n(%)	Self-harm at post-treatment in the comparator condition Mean (sd) or n(%)
DBT	Comprehensive community treatment	Turner 2000	Independent centre	Number of incidents per 6 months	14.08(3.73)	13.58(3.34)	0.75(1.23)	5.58(5.28)
	General psychiatric management	McMain et al. 2009	Independent centre	Number of incidents per 4 months	20.94(33.28)	32.19(81.94)	4.29(9.32)	12.87(51.45)
	Treatment-as-usual	Feigenbaum et al. 2012	Independent centre	Number of incidents per 6 months	4.1(4.3)	7.8(4.7)	2.4(3.2)	3.1(3.4)
		Koons et al. 2001	Independent centre	Number of incidents per 3 months	5.1(13.2)	0.7(1.3)	0.40(1.3)	1.0(2.2)
		Linehan et al. 1991	Treatment developer	Number of incidents per 4 months	3.50(7.88)	15.91(25.02)	0.55(0.94)	9.33(26.95)

		Priebe et al. 2012	Independent centre	Number of incidents per 2 months	14.7(20.3)	13.0(16.3)	4.8(13.5)	13.5(22.2)
MBT	Structured clinical management	Bateman & Fonagy 2009	Treatment developer	% engaging in severe self-harm per 6 months	55(77.5%)	46(73.0%)	17(23.9%)	27(42.9%)
				Number of severe self-harm incidents per 6 months	4.11(4.90)	3.75(3.69)	0.38(0.83)	1.66(2.86)
				% making a life-threatening suicide attempt per 6 months	53(74.6%)	42(66.7%)	2(2.8%)	16(25.4%)
	Treatment as usual	Bateman & Fonagy 1999	Treatment developer	Number of incidents per 6 months	Median = 9	Median = 8	Median = 1	Median = 6
				% attempting suicide per 6 months	94.7%	75(?)%	5.3%	60%

DBT = Dialectical behaviour therapy; MBT = Mentalization based therapy