A mentalization-based approach to common factors in the treatment of borderline personality disorder

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Abstract

In this paper we conceptualise borderline personality disorder as a disorder of mentalizing, social cognition, and loss of resilience. Several treatment approaches are effective, and meta-analyses suggest that there are few substantive differences in effectiveness between them and between specialized and non-specialized approaches. We propose that these findings arise because of shared mechanisms of change, congruent with current thinking both about the existence of a general ‘p’ factor of psychopathology and a reconceptualization of personality disorders as involving a lack of resilience resulting from problems with epistemic trust and salutogenesis, the capacity to derive benefit from the social environment. Effective treatments share the characteristics of consistency, coherence and continuity, qualities particularly relevant to borderline personality disorder. They create the conditions for the reopening of

epistemic trust, an essential component in therapeutic change, as it enables the individual to use the experience of being mentalized, to learn mentalizing of others, and then apply and develop these experiences in day-to-day life, which is the basis for meaningful therapeutic change.

Highlights

- Idea of common factors supports a dimensional conceptualization of personality disorders.
- Personality disorder can be considered, in part, as maladaptive communication
- Treatment needs to address interpersonal and social communication systems to establish therapeutic change.
- Opening of epistemic trust via therapy allows for social learning outside treatment.

Introduction

Borderline personality disorder (BPD), historically regarded as difficult to treat, is now treatable with treatments bringing about real improvements in the quality of life of individuals with the diagnosis [1]. Recent meta-analyses report that several treatment approaches are effective [1-3]. Furthermore, differences in effectiveness between specialized and non-specialized treatments do not seem to be very substantial. A recent meta-analysis found a small to moderate effect size difference between these types of treatments at treatment termination, which, largely disappeared at follow-up [1]. In particular, in studies where the control condition was strong (i.e. in manualized treatments such as general psychiatric management and to some extent in structured clinical management) there were no significant differences in treatment effect. There may be some methodological reasons behind these findings, but they should also serve as a warning to all treatment developers of the

dangers of making assumptions about what constitutes the active ingredient(s) of treatments [4]. What is more, the findings of this meta-analysis should not come as a surprise: since 1975, meta-analyses have found that no *bona fide* form of psychotherapy is superior to another, and that therapeutic change does not depend on specific, “branded” techniques [5-8].

Therapeutic change

We would, however, caution against reacting to such findings by abandoning any attempt to make sense of the mechanisms that underpin therapeutic change beyond making rather passive inferences about the power of the therapeutic alliance. Similarly, although clinicians often assume that the techniques they use in the consulting room are the primary driver of change, this seems unlikely. In fact, we have very limited knowledge about the moderators and mechanisms of change in psychotherapy itself, let alone in more complex psychosocial treatments. As an example, Neacsiu et al. [9] examined the role of dialectical behavior therapy (DBT) skills in improving treatment clinical outcomes in BPD. Unsurprisingly, participants treated with DBT reported using three-fold more behavioral skills by the end of treatment than participants assigned to a control treatment. Use of DBT skills was shown to mediate the decrease in suicide attempts and depression and the increase in control of anger, suggesting that skills acquisition and practice may be an important mechanism of change in DBT. However important this effort may be, though, it creates an illusion of an explanation, which fails to explain how patients treated with general psychiatric management in a randomized controlled trial comparing this intervention with DBT changed equally without receiving any skills training [10,11]. On the basis of this and similar findings we have advanced the hypothesis that all effective interventions validate the patient’s sense of agency and so stimulated mentalizing processes, which enabled the patients to make use of the techniques of the therapy to benefit from experiences in their day-to-day life. From this

perspective, change is thought to be brought about by what happens beyond therapy, in the patient's social environment. Studies in which change was monitored session by session have suggested that the patient–clinician alliance in a given session predicts change in the next [12]. This suggests that the change that occurs between sessions is a consequence of changed attitudes to learning from social experience engendered by therapy, which influences the patient's behavior between sessions.

We propose that psychotherapeutic interventions that are able to create such changes in personality disorders (PDs) share "three Cs": *consistency*, *coherence* and *continuity*. These qualities are particularly pertinent in the treatment of BPD, a disorder in which metacognitive organization is often substantially lacking [4]. Indeed, metacognitive disorganization may be one of the key unifying features of the disorders currently categorized as PDs in the psychiatric classification systems. The categorical approach to PDs, as presented in Section II of the DSM [13], provides 10 discrete diagnostic categories of PD. In our opinion, it is not fit for purpose. The attempt to categorize BPD, for instance, in this way is undermined by high comorbidity and within-diagnosis heterogeneity, marked temporal instability, the lack of a clear boundary between normal and pathological personality, and poor convergent and discriminant validity [14]. This suggests that the various available evidence-based treatments with seemingly equivalent outcomes may have been studied in different populations and may not in fact be equally applicable to all subtypes of BPD. For these reasons, the proposals for ICD-11 [15] attempt to break away from categorization, dispensing with borderline as a concept altogether, using the alternative concept of trait domains. This can be understood as constituting a way of making sense of a patient's behaviours in terms of severity and typical styles of behaviour and their underlying cognitive processes.

Mentalizing

One possible answer to questions about the definition of PD and suggestions of common factors underpinning effective treatment is that PD is best considered, in part, as a problem with mentalizing or social cognition, and that the development of more robust mentalizing is a shared factor in all successful therapies. Mentalizing can be defined as thinking about one's own and others actions in terms of thoughts and feelings, and using this knowledge of mental states to master life challenges, or to designate them as "just thoughts" that do not need to be acted on – or that, by contrast, need to be seriously and maturely considered for the purpose of reflection. Inevitably, this view is appealing to us as developers of mentalization-based treatment (MBT) [16]. Deficits in mentalizing do indeed appear to be a conspicuous feature of PDs. This allows reconceptualization of PD in terms of mentalizing profiles and the development of targeted treatment, and partly explains why MBT and other types of treatment may be effective with a range of PDs and other disorders [16,17]. In the case of BPD, which (as we shall discuss in more detail in the following sections) may be understood as paradigmatic of PDs in general, there are specific distortions or imbalances in mentalizing that typically manifest, particularly in situations of interpersonal stress or challenge.

Improvements in reflective function do indeed appear to occur in effective therapy [18,19]. This outcome is shared by different treatment modalities, as they all bring about changes in social cognition – that is, the expectations that people have about each other and themselves in relation to thoughts and feelings. Mentalizing is thus thought to be an inherent part of all effective psychotherapies. But deliberately and explicitly focusing on this capacity, and working to enhance it, is what distinguishes MBT from other interventions [16].

However, perhaps surprisingly, we also suggest that recognizing that mentalizing has a significant role in the process of change that takes place in MBT and other effective therapies does not really explain the underlying shared mechanism at work in these

treatments. For this we consider it necessary to recognize how individuals 'learn' or fail to learn about themselves and the social world.

Epistemic trust and personality disorder

The epistemic trust model of understanding psychopathology requires an integrative and dimensional approach. We argue that resilience – or its absence, which is typical of PDs – may be the outcome of the dynamics of the relationship between the social environment as a system and individual differences in the capacity for higher-order cognition (e.g. mentalizing) in relation to this system. To effect change it is necessary to understand the nature of resilience; this requires therapeutic work at the level of the psychological mechanisms that channel and process the interplay between the social layer of communication on the one hand, and the individual's capacity for reorganizing reciprocal mental processes on the other hand. Hence, from this it follows that attempts to intervene at the level of non-resilient responses – that is, at the level of symptoms only, for example – will be of limited effectiveness.

To understand the nature of resilience, we rely on a compelling and growing body of research concerning the role of a general psychopathology, or 'p', factor [20] that is providing increasing evidence to suggest that the traditional taxonomic model of categorizing psychopathology may ultimately be replaced by a more overarching dimensional view. Caspi et al. [20] first demonstrated that vulnerability to mental disorder was more convincingly described by one general psychopathology factor (labelled the p factor) than by three high-order factors (internalizing, externalizing, and thought disorder). A higher p factor score was also associated with "more life impairment, greater familiality, worse developmental histories, and more compromised early-life brain function" ([20], p. 13). This line of thinking

has been developed by recent studies extending the validity of the p factor concept into childhood and adolescence [21-28].

Furthermore, a study by Sharp et al. [29] explored whether there is a general, overarching PD factor that underlies different PD diagnoses. Sharp et al. [40] evaluated a bifactor model of PD criteria in which a general factor and several specific factors accounted for PD criteria covariance with BPD criteria loading solely on the general factor while other PDs loaded both onto a general and specific factors. It appears that BPD thus might be understood as the core construct of personality pathology more generally; this would help to make sense of the high levels of comorbidity found in BPD patients. More specifically high 'p' seems to indicate a lack of resilience to life stressors and a persistent vulnerability over time due to inability to learn from personal experience and the experience of others, which forms the basis of a social communication disorder such as BPD. We posit that the statistical constructs that these studies point to are thus measurements of an individual's level of epistemic trust, by which we mean their confidence in the authenticity and personal relevance of interpersonally transmitted knowledge [30]. The evolutionary purpose of epistemic trust is to encourage social learning in an ever-changing social and cultural context, by enabling individuals to be open to benefit from their (social) environment. This mechanism for opening the channel to social learning exists because it cannot be left open by default: it is adaptive for humans to adopt a position of epistemic vigilance towards another person unless they are reassured that that person's intentions in communicating are not malign [31,32]. The disruption of epistemic trust – or the emergence of outright epistemic mistrust as a result of environmental adversity, genetic propensity or an interaction between the two – can lead to a fundamental breakdown in the capacity for the exchange of social communications that can protect against the emotional dysregulation, impulsivity and social dysfunction that characterize individuals with entrenched and severe mental health difficulties.

In the case of individuals with PD, the entrenched and enduring nature of the pathology, which traditionally led to the perception that, for example, patients with BPD were almost impossible to treat, is a reflection of the epistemic mistrust that is characteristic of the disorder and makes the patient appear rigid and “hard to reach”. An individual experiencing a single-episode case of mental disorder may be amenable to brief, focused forms of treatment, such as a short course of cognitive-behavioral therapy; however, this would be ineffective for an individual with a high p factor – that is, someone suffering from high levels of comorbidity, longer-term difficulties and greater impairment. These patients require longer-term therapy that is highly mentalizing and rich in the ostensive cues that serve to stimulate epistemic trust and openness. It is only through this process that epistemic trust can be reopened and the patient can experience the benefits of improved social knowledge within their wider social environment [30,33].

In line with these assumptions, we therefore believe that the “borderline mind”, and related severe problems with social communication typically observed in what is commonly referred to as “personality pathology”, may best be understood as a socially triggered outcome based on a learned expectation about the social and interpersonal environment. An informing principle is that the type of functioning associated with BPD might best be understood as an evolutionarily driven form of entrenched adaptation to stimuli from the social context – often in interaction with genetic propensity [34] – rather than as a deficit.

The psychotherapeutic communication systems

The views outlined above have led us to rethink our assumptions not only about the core features of personality pathology, but also about the factors responsible for therapeutic change. Specifically, they have led us to develop a new approach to the question of common versus specific factors in explaining therapeutic change. In sum we suggest three

communication systems, which balance common and specific factors of therapy underpin therapeutic change. These are outlined in Box 1. This view can be situated between current approaches and provides a decisively different view on the role of the therapeutic alliance in explaining the effects of specific and common factors. MBT itself is currently being adapted to reflect this understanding by introducing clinical intervention related to all three communication systems discussed below rather than relying on the first two.

[insert Box 1 about here]

Communication System 1: The teaching and learning of content

We suggest that the different therapeutic schools belong to this system. They may be effective primarily because they involve the therapist conveying to the patient a model for understanding the mind that the patient can understand as involving a convincing recognition and identification of his/her own state. This may in itself lower the patient's epistemic vigilance.

Communication System 2: The re-emergence of robust mentalizing

When the patient is once again open to social communication in contexts that had previously been blighted by epistemic hypervigilance, he/she shows increased interest in the therapist's mind and use of thoughts and feelings, which stimulates and strengthens the patient's capacity for mentalizing.

Communication System 3: The re-emergence of social learning

The relaxation of the patient's hypervigilance via the first two systems of communication enables the patient to become open to social learning. This allows the patient to apply his/her new mentalizing and communicative capabilities to wider social learning, outside the consulting room. This final part of the process depends upon the patient having a sufficiently benign social environment to allow him/her to gain the necessary experiences to validate and bolster improved his/her mentalizing, and to continue to facilitate the relaxation of epistemic mistrust, in the wider social world.

Discussion and conclusions

Recent meta-analytic findings about the effectiveness of various treatment approaches to BPD, including non-specialized ones, dovetail with a more longstanding narrative that emerges from a systematic review of the literature on the effectiveness of psychotherapy more generally: that no one treatment modality is able to claim supremacy. In this review we have argued that the implications of these findings, especially when considered in conjunction with a compelling seam of recent research on the p factor in psychopathology, support the conceptualization of a new dimensional model of personality pathology, and the role of the three communication systems listed above in driving therapeutic change across all effective treatments for a range of psychological disorders, and for personality disorders in particular. Future research is needed to further investigate these assumptions.

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Declaration of interest

Anthony Bateman, Patrick Luyten and Peter Fonagy are involved in the development, training, evaluation and dissemination of mentalization-based treatments.

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Box 1: Common and specific processes related to change

Communication System 1: **General processes common to all therapies**

- Recognition of the patient's problem
- A persuasive model of understanding the mind
- Coherently adapting the general model to provide a 'felt experience' of relevance and pertinence to the patient
- Generation of a process of learning
- Management of arousal
- Management of interpersonal distance

Communication System 2: **Generating a mentalizing process and increasing sensitivity to ostensive cues**

- Consistently recognising the patient as agentive
- Marking the patient's experiences
- Implicitly and explicitly acknowledging the patient's emotional state
- Modelling constructive mentalizing
- Presenting alternative perspectives
- Promoting relational mentalizing
- Challenging inadequate mentalizing or non-mentalizing as appropriate

Mentalizing creates increased sensitivity to ostensive cues:

- Enhances the process of transmission of socially and individually relevant content from the therapist to the patient
- Information from therapist in relation to the patient's life becomes generalizable, experienced as relevant and is retained (i.e. it is internalized)
- Generates expectation of personal relevance social value of information exchange between people
- Beneficial effect of an open and trustworthy relational environment

Communication System 3: **Re-emergence of the potential for social learning beyond the therapy context**

- Enhanced sensitivity to ostensive cueing, leading to the patient feeling recognized as agent in increasing number of social contexts
- Retreat from the epistemic dilemma of epistemic hypervigilance and epistemic credulity causing epistemic isolation
- Willingness to test therapeutic wisdom (learnings from the therapist) in the social world
- Updated expectations about others, and the self in relation to others, within a social matrix
- Improved epistemic trust in vivo in new social encounters, leading to improved potential for new relationships and also refreshing of past links
- Robust mentalizing sustained by improved social connections
- Smoother and fuller connection to the social world, leading to greater social acceptance and decreased rigidity in social interactions
- Increased resilience in the face of life challenges