Stepped Care: An Alternative to Routine Extended Treatment for Patients With Borderline Personality Disorder

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This review examined evidence supporting stepped care for borderline personality disorder as an alternative to routine extended treatment. Empirical studies have shown that patients with borderline personality disorder have a heterogeneous course, but symptomatic improvement can sometimes be relatively rapid. Currently, there is no evidence that any long-term treatment is superior to briefer interventions for borderline personality disorder. Long-term therapy may not be necessary for all patients, and its routine use leads to access problems. A stepped-care model, similar to models applied to other severe mental disorders, might provide a better use of resources. Stepped care can be used to limit the use of expensive programs and reduce waiting lists. Not all patients with borderline personality disorder can be treated briefly, but a stepped-care model allows those with less severe symptoms to be managed with fewer resources, freeing up more time and personnel for the treatment of those who need treatment the most. (*Psychiatric Services* 64:1035–1037, 2013; doi: 10.1176/appi.ps.201200451)

Borderline personality disorder is a complex and multidimensional disorder with a wide range of comorbidity, characterized by traits of affective instability and impulsivity (1). The disorder usually begins in adolescence, continues over the young adult years, and remits over time (2,3). Although the outcome of the disorder is variable, it can be influenced by comorbidity, particularly when substance abuse is also present (4). A chronic course might suggest that treatment for the disorder needs to be lengthy, but patients who meet criteria for this diagnosis can be heterogeneous in clinical features and outcome, and not all require the same treatment. Some patients recover surprisingly rapidly, and although the disorder fails to remit for a few, most show a gradual but clinically significant improvement over time (2,3). Long-term follow-up shows that borderline personality disorder has a relatively good prognosis; however, most patients continue to experience some degree of psychosocial dysfunction. Because treatment for these residual difficulties is untested, focusing resources on acute symptoms may be a more evidence-based strategy.

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Treatment options for borderline personality disorder

Studies of treatments for borderline personality disorder usually examine patients who come regularly for treatment. However, many patients are seen intermittently, and those who recover early may stop coming entirely (4). Because practitioners are more likely to see chronic patients who fail to recover, they can be less familiar with those who do—a scenario called Berkson's bias (5). Although several psychotherapies have been shown to be effective for the symptoms of borderline personality disorder (6), these procedures tend to be lengthy. Brief interventions could be a better investment of scarce resources. In the general research literature on psychotherapy outcome, most studies suggest that effects tend to plateau after about six months (7). In borderline personality disorder, the psychotherapies that have demonstrated effectiveness last for about a year; however, interventions could be streamlined into a shorter time frame, as several studies have suggested (8–10).

It is also possible that extended courses of therapy in borderline personality disorder could be harmful for some patients. Gunderson (11) remarked that much of the pessimism about borderline personality disorder results from the use of inappropriate long-term treatment models. Even evidence-based therapies based on cognitive models have time scales involving years of treatment. Thus dialectical behavior therapy (DBT), which has a strong evidence base for efficacy, was originally described as a treatment that could last for several years (12), although only the "first stage," lasting about a year, has been evaluated in clinical trials. Currently, there is no evidence that any long treatment is superior to briefer interventions for borderline personality disorder (6), and the complex "package" that DBT offers does not yield results superior to general psychiatric management (13). Also, although patients retain functional disabilities when they no longer meet criteria for the disorder, offering a more extended course of the same treatment has not been shown to resolve these problems.

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The same issues arise with other methods that have undergone clinical trials, such as mentalization-based treatment. However, Bateman and Fonagy (14) have suggested applying this approach more briefly, by teaching its principles to nurses and other mental health professionals (15). Several other therapies have also been tested (6), but no trials have directly compared psychotherapy for borderline personality disorder in brief and extended forms. Yet the briefer and more practical option of Systems Training for Emotional Predictability and Problem Solving (STEPPS) has broad empirical support (10).

In summary, although evidence-based treatments for borderline personality disorder have had encouraging results in clinical trials, they tend to be lengthy and not sufficiently accessible. This raises the question of whether some patients can be managed with briefer interventions.

Brief interventions can be effective

Evidence shows that some patients with borderline personality disorder respond well to brief interventions. Stanley and colleagues (8), who examined results of clinical trials of DBT, observed that most gains occurred in the first few months. Davidson and colleagues (9), who examined the efficacy of standard cognitive-behavioral therapy (CBT), reported a significant improvement after a mean of 26 sessions. Clinical trials of STEPPS showed that a 20-session program can be highly effective (10). STEPPS was developed as an adjunct to treatment as usual, but it is an effective intervention in its own right. All of these methods are superior to treatment as usual, which tends to be unfocused and does not include interventions, such as emotion regulation, that are more specific for borderline personality disorder. Another important element of effective treatment in DBT, CBT, and STEPPS is psychoeducation, and several studies have found that even brief interventions that involve psychoeducation can yield symptom reduction (6).

These findings suggest that longer treatments need not be routinely prescribed but can be reserved for those who do not respond to briefer interventions. Thus Zanarini (6) recommended that "less intensive and less costly forms of treatment need to be developed," and McMain and colleagues (13) suggested that "given the lack of availability of effective treatments for borderline personality disorder, research is needed on the effectiveness of less-intensive models of care in order to help inform decisions about the allocation of scarce health care resources."

Access to treatment

Because borderline personality disorder is usually treatable with evidence-based methods, access to therapy for patients with the disorder should be a priority for the mental health system. The problem is that current evidence-based psychotherapies, although more effective than past procedures, are still lengthy and expensive. Long-term therapy creates serious problems in access to treatment: any program that lasts for one to two years quickly becomes closed to new patients, leading to waiting lists that do not serve the needs of patients, who usually enter the mental health system in a crisis and who are not particularly good at waiting when acutely distressed. Even if psychotherapies are costly, the mental health system would be justified in funding them if, as in the case of procedures such as cardiac surgery, it could be demonstrated that expensive therapy works and that cheaper therapy does not. However, there is no empirical support for that conclusion in borderline personality disorder.

Over the last few decades, brief methods of psychotherapy for common mental disorders have largely replaced long-term models that were once considered standard. Shorter therapies are a "default," with longer therapies held in reserve for more difficult cases. Most psychotherapy delivered in the community is time limited (16) and is efficacious for most patients (5). A classic study of a large clinical sample found a rapid decline in symptoms for most patients within the first few weeks of therapy, with asymptotic flattening around the 20-week mark, whereas a subgroup in the cohort with problematic personality traits did not benefit from longer treatment (17). Although some meta-analyses of long-term treatment have claimed that complex pathology requires longer therapy (18), they have yielded only small effect sizes.

Stepped care

A "stepped care" model for the management of general medical and mental disorders (19,20) has been developed for conditions for which access to care is a problem. The model is particularly appropriate for disorders that have a high prevalence but vary greatly in prognosis and outcome. The underlying concept is that some patients benefit from minimal interventions, such as psychoeducation, physical exercise, or watchful waiting, allowing clinicians to see whether they recover spontaneously or respond to simple interventions. As described in a clinical trial of stepped care for posttraumatic stress disorder (21), clinicians can provide acute services, followed by regular monitoring and follow-up. Thus therapists do not need to define full remission as the end-point of an intervention but can set less ambitious goals, aiming for a level of recovery after which patients carry out self-care with intermittent follow-up.

The stepped-care model can be of particular value in conditions with symptoms that tend to remit over time, as is the case for borderline personality disorder. Because the burden of the disorder is high, scarce resources need to be triaged. In many ways, patients with the disorder tend to "step up" their own care, moving in and out of the system, so that only a minority remains in long-term treatment (4). However, patients with more severe and chronic symptoms, who use more resources and stress the system, may gain particular benefit from a stepped-care model. Patients who show a response to acute treatment can be followed intermittently, and regular monitoring can focus on the most serious outcomes, such as suicidality and self-harm. Applying the DBT model (13), the clinician could also monitor life-threatening and treatment-interfering behaviors, behaviors that interfere with quality of life, and improvements in behavioral skills.

Stepped care is a kind of clinical experiment, in which patients are

offered different grades of intervention depending on treatment response. Younger patients with acute symptoms, who are more likely to show early recovery (3), could be the best candidates for brief intervention. Because further gains often take place after formal therapy ends, it may be useful to discharge these patients to the community while allowing for reentry to the mental health system. If this "step" should fail, patients who do not improve or who quickly relapse after a short course of therapy can be referred either to more intensive time-limited treatment, as in a day hospital, or to a longer course in an outpatient clinic. At each step, monitoring of progress would prevent "drift," with further acute interventions geared to the intermittent course of the disorder. For most patients, such a program will involve providing acute interventions and maintaining treatment availability between episodes. However, a minority of more severely ill patients will require maintenance therapy.

Patients with borderline personality disorder are common in the community (22), and stepped care could make services for them more practical and less costly. Having a program with a one-year waiting list does little for the many patients with acute symptoms who continuously enter the system. Stepped care would also allow patients with less severe symptoms to move out of crisis mode and become symptomatically stable. Even if some of these patients continue to have some degree of dysfunction and retain intermittent contact with the mental health system, they do not necessarily need continuous follow-up (23). There will also be some patients who are not ready for therapy and may not accept it if offered, remaining in a "precontemplation" phase (24); but clinicians can wait until they are ready.

Finally, providing brief treatment for patients who present with more acute symptoms would allow specialized personality disorder clinics to be more accessible and would limit or eliminate waiting lists. Not all patients can be treated briefly, but a stepped-care model allows those with less severe symptoms to be managed with fewer resources, freeing up more time and personnel for the treatment of those who need treatment the most—patients who are chronic users of services and who require rehabilitation programs.

Conclusions

A stepped-care model is consistent with the existing literature on the treatment of borderline personality disorder, but it requires specific testing in clinical trials. If this approach can be shown to be effective and cost-effective, it could make treatment more accessible and allow for better planning of psychiatric services.

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