

# **Is Borderline Personality Disorder a Moral or Clinical Condition? Assessing Charland's Argument from Treatment**

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## **Abstract**

Louis Charland has argued that the Cluster B personality disorders, including borderline personality disorder, are primarily moral rather than clinical conditions. Part of his argument stems from reflections on effective treatment of borderline personality disorder. In the *argument from treatment*, he claims that successful treatment of all Cluster B personality disorders requires a positive change in a patient's moral character. Based on this claim, he concludes (1) that these disorders are, at root, deficits in moral character, and (2) that effective treatment of these disorders requires a sort of moral education rather than clinical intervention. In this paper, I evaluate the *argument from treatment* through a critical analysis of two psychotherapeutic interventions that have shown recent effectiveness against borderline personality disorder. I suggest that both Dialectical Behaviour Therapy and Mentalization-Based Treatment indicate that borderline personality disorder is, at root, a deficit in non-moral cognitive and emotional capacities. I suggest that these non-moral deficits obscure the expression of an otherwise intact moral character. In light of this, I conclude that effective treatment of borderline personality disorder requires primarily clinical intervention rather than moral edification.

## **1. Introduction**

Is borderline personality disorder (BPD) a fundamentally moral condition or a fundamentally clinical condition? Recently, philosophers and psychiatrists have shown an increasing amount of attention to the more general question of whether all Cluster B

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personality disorders (CBPDs)<sup>1</sup>, including BPD, are moral conditions or clinical conditions. This interest is not surprising, given that up until the past two decades, CBPDs have proved recalcitrant to clinical treatment, and BPD especially so [2]. The debate surrounding this question was largely instigated by Charland [3], who put forth a sharp and provocative two-pronged argument that attempts to show that CBPDs are primarily moral, rather than clinical, kinds.<sup>2</sup>

The first prong of Charland's argument, which he calls the *argument from identification*, uses philosophical analysis of the language used in the *DSM-IV* [1] to reveal that CBPDs cannot be defined without use of moral terms. The second prong, called the *argument from treatment*, starts with the apparent empirical observation that successful treatment of CPBDs almost always requires a change in moral character of the client. Based on this claim, the argument concludes that if CPBDs require moral conversion for successful treatment, then CPBDs are likely moral deficits and treatment of them is likely a form of moral education.

Zacher and Potter have challenged Charland's thesis by attacking the first prong of his argument [5]. Whether or not this critique is successful, Charland has pointed out that Zacher and Potter leave the second prong of his argument untouched [4]. This paper aims to fill this gap.<sup>3</sup> I will assess the *argument from treatment* through an up-to-date and detailed analysis of successful therapeutic interventions for one particularly clinically challenging CBPD, namely BPD.

I have chosen to focus on only BPD, and not on the other CBPDs, because while Charland intends his *argument from treatment* to apply to all CBPDs, his argument is built mainly around an analysis of one treatment of only BPD, namely Dialectical

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<sup>1</sup> According to *DSM-IV* classification [1], the Cluster B personality disorders are antisocial personality disorder, narcissistic personality disorder, histrionic personality disorder, and borderline personality disorder.

<sup>2</sup> Charland does not think the two categories are mutually exclusive [4].

<sup>3</sup> Pearce comments on the second prong, but provides no detailed analysis of it beyond a mention that some evidence shows that some CBPDs are responsive to pharmacological and psychotherapeutic treatments [6].

Behaviour Therapy (DBT) [3, 4]. Indeed, Charland draws no evidence from any other treatment of any other CBPD. This focus is understandable given that BPD is the only CBPD to show responsiveness to psychotherapeutic intervention. Nevertheless, the success of Charland's argument thus depends crucially upon whether or not his interpretation of DBT - as a form of moral education - is accurate. I will attempt to show that this view is not empirically supported. Of course, it is possible that empirical evidence from other treatments of other CBPDs can be used to support Charland's conclusion. However, he has not yet presented such evidence. Accordingly, I will not address the treatment of any other CBPDs here. To be clear, the thrust of this paper is to refute Charland's claim that the nature of effective treatments of BPD suggest that BPD is a moral condition.

I will conclude, based on my analysis, that although successful treatment of BPD necessarily includes the attainment of moral treatment goals, the disorder itself cannot be classified as a fundamentally moral deficit. Key to my argument will be the suggestion that immoral behaviour of people with BPD may be rooted not in a deficit in their moral character, but in cognitive and emotional deficits that obscure the expression of an otherwise intact moral character. If correct, this analysis suggests that though successful treatment of BPD results in improvements of immoral behaviour, the treatment itself is fundamentally a clinical treatment – of cognitive and emotional capacities – and not fundamentally a moral treatment.

I will perform analyses of two types of therapy used to treat BPD. The first is DBT [7, 8]. Charland's psychotherapeutic empirical evidence for the *argument from treatment* is garnered exclusively from DBT [3]. This is understandable, given that DBT was for many years considered to be perhaps the only successful psychotherapy for BPD [7]. However, in recent years, Mentalization-Based Treatment (MBT) has accrued a notable amount of empirical support as an especially effective long-term treatment of BPD [9, 10]. For this reason, the latter portion of this paper will ask whether MBT should be classified as a primarily moral treatment or a primarily clinical treatment.

The paper proceeds as follows. In section 2, I unpack Charland's *argument from*

*treatment* in greater detail, and formally argue for a two-step interpretation of it. In section 3, I assess whether DBT supports the *argument from treatment*. In section 4, I turn to MBT and conduct a similar analysis. I conclude that both DBT and MBT support the thesis that BPD is, at root, a clinical condition. Accordingly, successful treatment of BPD requires primarily clinical intervention and not primarily moral intervention.

## **2. The argument from treatment**

I contend that Charland’s *argument from treatment* can be broken into two steps, and that the two steps need not be taken together. I will argue for the individuality of each step here.

### **2.1 Moral behaviour and moral character**

The first step can be seen in the following consideration that Charland makes about CBPDs:

...it is impossible to imagine a successful treatment or cure for those conditions that does not involve some sort of conversion or change in moral character... unless the moral problems and behaviors associated with the Cluster B disorders can be overcome or eliminated, successful treatment and cure is impossible [3:122].

The first step, then, is the observation that successful treatment of CBPDs necessarily involves an alleviation of “moral problems and behaviours associated with the Cluster B disorders.” It is important to see that though this step relates to empirical observation, it is really a logical point. Given that immoral behaviour partially defines the CBPDs – for example, the “inappropriate, intense anger” and “instability in interpersonal relationships” of BPD [1] - then it is conceptually necessary that successful treatment of CBPDs involves overcoming immoral behaviour.

However, in light of this, there is a further distinction that needs to be drawn out of the above passage. The distinction is between *moral behaviour* and *moral character*. In addition to mentioning a requisite change in “moral problems and behaviours”, Charland also suggests that successful treatment involves a “sort of conversion or change

in moral character.” He suggests this latter change is “tantamount to a moral conversion” [3:122].

First, let us define the key terms at play here. *Moral behaviour* consists of actions with moral dimensions. Examples of moral behaviours with a negative moral dimension include angry outbursts, lying, and manipulation. *Moral character*, in contrast, consists of the underlying personality traits that may or may not give rise to moral behaviour. Moral character includes beliefs, desires, values, etc.

In light of Charland’s mention of both types of change, we can ask: is a change in moral behaviour equivalent to a change in moral character, and further, are both changes required for successful treatment of BPD? I contend that they are not. Notice that the diagnostic criteria that define BPD, and therefore the criteria that must be overcome in any successful treatment of the condition, are clearly behavioural traits, but they are not clearly character traits – namely, “inappropriate, intense anger” and “instability in interpersonal relationships.” To see this point plainly, consider the following two cases.

First, if a person who engages in immoral behaviour undergoes an elimination of that behaviour - angry outbursts are tamed, and interpersonal relationships gain stability – then the diagnostic criteria of BPD are no longer satisfied, and successful treatment is logically possible. It is not logically possible that the relevant behaviour could cease and those diagnostic criteria could still hold. Second, and on the contrary, if a person’s moral character was to undergo a conversion – for example, if they lose a desire to manipulate or deceive others and tap an inner source of compassion – then this person could logically still behave in an immoral manner (perhaps via imagined or real coercion from a third party) contrary to their moral character. In this case, since the “inappropriate, intense anger” and “instability in interpersonal relationships” could conceivably continue despite moral character change, we cannot say that successful treatment of BPD necessarily involves moral character change. Successful treatment of BPD, then, requires moral behaviour change, but not necessarily moral character change.

Three objections may naturally arise to my argument here. First, one may object that my second example – of a person coerced into immoral action against their desires –

is too highly contrived to be meaningful. They may argue that even if “moral conversion” were accompanied by the continuation of certain immoral actions, this moral change would very likely lead to a reduction in some of the other polythetic criteria of BPD, and thus could possibly result in successful treatment. However, this objection is misplaced, simply because the empirical plausibility of this example is not relevant to the logical point the example is intended to make. The point is that it is logically possible that moral character can change without any attendant moral behaviour change.<sup>4</sup> This philosophical point illustrates that moral character and moral behaviour must be distinguished from each other. Once this difference is established, we recognize that, following directly out of the diagnostic criteria in the *DSM-IV*, successful treatment of BPD requires a change in moral behaviour, but not necessarily a change in moral character. This is the first step of Charland’s *argument from treatment*.

Second, one may object that I have simply misinterpreted what Charland means by “conversion or change in moral character.” I have suggested that a change in moral character means a change in beliefs, desires, or values that may or may not translate into behaviour change. Yet, perhaps Charland did not intend such a deep change. Perhaps “moral conversion”, for Charland, is simply a behavioural change, with or without an attendant change in values, beliefs, desires, etc. This objection is weak, however, because it is highly unlikely that Charland intends only a behavioural interpretation of “moral conversion”. He makes clear elsewhere that “...full cure requires moral willingness, moral change, and moral effort” [12]. Willingness is not something that can be cased out in behavioural terms. Rather, willingness suggests a value or desire to engage in some act. Moral conversion, then, includes value or desire change.

Third, one may object that Charland may have intended a mixed interpretation of “moral character,” where the concept refers to beliefs, values, desires, *and* behaviours all taken together. The problem with this objection is that if we accept a mixed interpretation

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<sup>4</sup> There is actually a body of empirical evidence that suggests a dissociation between moral behaviour and moral beliefs in non-coercive cases [11]. In light of this, my example of a change in moral character, accompanied by no change in moral behaviour, may not be entirely unrealistic.

of moral character, then the concept of “moral conversion” loses its specificity. For example, does a change in only beliefs, values or desires, but not in behaviours (recall the above example of coercion), constitute a moral conversion? Conversely, does a reduction of immoral behaviour, with no change in beliefs, desires, or values, constitute a moral conversion?<sup>5</sup> Since Charland claims that successful treatment of CBPDs “is tantamount to moral conversion”, then it is important to be clear on exactly what counts as moral conversion. Being clear on this point may have large ramifications for what type of treatment is required to precipitate a moral conversion. Therefore, a mixed interpretation of moral character would need to be further detailed into an account that can answer these questions.

## **2.2 What underlies behaviour change?**

Given the distinction between moral character and moral behaviour laid out above, the individuality of the second step of the *argument from treatment* becomes clearly apparent. The second step is the inference from the first step to the conclusion that the causes of CBPDs are deficits in moral character, where moral character is understood to be comprised of values, beliefs, desires, etc. In other words, the second step holds that given the efficacy of treatments that result in behavioural moral improvements, it seems likely that the reason those treatments are effective is because they target a deficit in the condition of the moral character of the client. This inference can be seen in Charland’s words here:

The fact that the moral treatment covertly practiced in DBT is apparently so appropriate and successful for treating borderline personality disorder is a good empirical indication that the borderline syndrome is at least partly a moral condition [3:124].

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<sup>5</sup> This situation is not only conceivable, but is actually very common in BPD patients. These patients are known to be able to control their negative behaviours in some instances, perhaps via inhibiting malicious desires and intents [7:10]. These situations could be interpreted as cases where immoral behaviour has been curbed, but an underlying change in values, desires, or beliefs has not occurred.

I will call the interpretation of BPD suggested in this passage - that the cause of BPD is an impairment in moral character - the *moral deficit model*. In the next section, I will argue, based on analysis of DBT, that moral behavioural outcomes of a treatment may obtain even if the causes of a disorder are non-moral. I suggest there that Charland fails to take this possibility into account. Moreover, I will present empirical evidence that suggests the causes of BPD are in fact non-moral emotional deficits.

### **3. Dialectical Behaviour Therapy**

DBT was developed by psychologist Marsha Linehan in the 1980s and 90s specifically to treat chronically suicidal individuals. It quickly developed into a treatment for BPD [8]. The treatment is a form of cognitive behavioural therapy combined with mindfulness training developed from Buddhist meditative practice. DBT may have been the first psychotherapy to show experimental evidence of effectiveness against BPD [7].

#### **3.1 Moral outcomes**

Charland argues that a twin set of key features present in DBT – a moral treatment contract, and moral treatment goals – ensure that any successful treatment of BPD using DBT includes an improvement in moral behaviour [3]. In other words, in the context of DBT, the first step of the *argument from treatment* is manifest as these two features. Charland describes the moral treatment contract in this way:

Often that contract revolves around setting limits to manipulative threats of suicidal or other self injurious behavior. Establishing mutual respect between the therapist and the client is a major goal of this sort of contract and its special alliance [3:123].

Linehan further elaborates on the general commitment of respect that this contract includes:

...the therapy commitment is not unconditional. If the therapist finds it impossible to help the patient further, if the patient pushes the patient beyond his or her own limits... therapy termination will be considered. As I tell my patients, even a mother's love is not unconditional [7:114].

Charland notes the connection between the moral treatment contract and the second key feature of DBT, moral goals, when he says:

In many therapeutic contexts, these moral aspects of the professional-client relationship can be taken for granted, and some may be irrelevant. But in the case of borderline patients, for example, these moral desiderata actually count as goals that need to be achieved in therapy. Note, that they are moral goals [3:123].

The set of treatment goals, according to Linehan, are very specific. Note here their explicitly moral nature:

DBT is very specific on the order and importance of various treatment targets... Suicidal, parasuicidal, and life threatening behaviours are first. Behaviours that threaten the process of therapy are second. Problems that make it impossible to ever develop a reasonable quality of life are third in importance [7:97].

Clearly, DBT has moral boundaries inherent in treatment initiation and moral goals explicit in treatment progress. Thus, successful DBT treatment necessarily involves attaining moral outcomes. However, does having moral outcomes as a central feature of BPD treatment mean that the underlying cause of BPD is a moral deficit?

### **3.2 Non-moral causes**

Recall that second step of the *argument from treatment* is the inference from the fact that successful treatment of CBPDs requires moral behaviour change to the conclusion that the causes of CBPDs are deficits in moral character. The suggestion in this step is that root causes of BPD are, in Charland's words, "clear moral deficits in empathy and regard for others," or "moral shortcomings" [3:122]. This is the *moral deficit model*.

When it comes to DBT, however, Linehan suggests a very different model of the root causes of BPD. She describes the etiology of BPD thus:

DBT is based on a biosocial theory of personality functioning. The major premise is

that BPD is *primarily a dysfunction of the emotion regulation system*; it results from biological irregularities combined with certain dysfunctional environments, as well as from their interaction and transaction over time. *The characteristics associated with BPD [eg. “inappropriate, intense anger” and “instability in interpersonal relationships”] are sequale of, and thus secondary to, this fundamental emotional dysregulation [7:42 emphasis added].*

This passage names “emotional dysfunction” as the root cause of BPD, and suggests that the diagnostic characteristics of BPD, including immoral behavioural patterns, are *effects* of this “fundamental emotional dysregulation”. Now, is this root dysfunction a moral deficit? This is the vital question we must answer. If it is a moral deficit, then we must conclude that DBT supports Charland’s *moral deficit model*. On the other hand, if this root emotional dysfunction is primarily a non-moral deficit, then we must conclude that DBT does not support the *moral deficit model*.

No one can deny that morality intimately involves emotional factors. Clearly, then, we are not asking whether emotional regulation can be completely separated from moral regulation, or whether emotional deficits in general can be separated from moral deficits in general. Rather, we are asking whether the specific emotional deficits observed in BPD can plausibly be counted as deficits in the moral character of BPD clients.

In other words, we should be interested in whether people with BPD, who are observed to have emotional dysfunction, automatically have immoral values, desires, and beliefs. With regards to the immoral traits sometimes attributed to people with BPD [eg. 3:124], we can ask: do people with BPD have *values* of resentment and vindictiveness, *desires* to be deceitful and manipulative, and *beliefs* that these immoral actions are the right ones to carry out? The following passage, based on Linehan’s empirical research with BPD clients, suggests that none of these three characterizations are true of people with BPD:

Borderline and suicidal individuals frequently possess good interpersonal skills in a general sense. The problems arise in the application of these skills to the situations

that the patients encounter. They may be able to describe effective behavioural sequences when discussing another person encountering a problematic situation, but may be completely incapable of generating or carrying out a similar behavioural sequence when analyzing their own situation. Usually, the problem is that belief patterns and uncontrollable affective responses are inhibiting the application of social skills [7:151].

Nowhere does this passage suggest that BPD clients value hurtfulness, desire to be malicious, or believe that other people, or even themselves, should behave in an immoral manner. Rather, Linehan is clearly stating here that the immoral behaviour of BPD clients arises from circumstantial emotional overload of a perhaps otherwise intact base of moral values, desires, and beliefs. Thus, she seems to be suggesting that the specific nature of “emotional dysfunction” is not intimately tied up with moral character, though it may interfere with expression of that moral character.

Linehan further elaborates on the nature of the “emotional dysfunction” that leads to emotional overload here:

Problems in affect tolerance make it difficult to tolerate the fears, anxieties, or frustrations that are typical in conflictual situations. Problems in affect regulation lead to inability to decrease chronic anger or frustration. [These problems] make it difficult to turn potential relationship conflicts into positive encounters. Borderline individuals frequently vacillate between avoidance of conflict and intense confrontation [7:152].

Vacillation between avoidance of conflict and intense conflict further suggests that people with BPD do not value or desire to behave in hurtful ways, but rather are driven into it, in spite of their values and desires, by a dysfunctional emotional system.

Taking all of these empirical findings into account, I suggest that “fundamental emotional dysfunction” is not primarily a moral deficit, but is primarily a non-moral deficit that interferes with the expression of moral character. Since the root cause of BPD,

on this account, is a non-moral deficit, we must conclude that DBT does not support the *moral deficit model* of CBPDs.

If DBT does not support the *moral deficit model* of BPD, then why has this model been so popular amongst clinicians? Linehan suggests that one potential reason is simply that up until DBT was developed in the 1980s and early 1990s, BPD had proved especially difficult to treat:

And certainly, few therapies to date [1993] have been shown to be particularly effective in stopping the suffering of Borderline patients... When the patients do not improve, the therapists may begin to say that they are causing their own distress. The patients don't want to improve or change. They are resisting therapy. (After all, it works with almost everyone else)... In short, *the therapists make a very fundamental but quite predictable cognitive error: They observe the consequence of behaviour (e.g., emotional suffering for the patients or themselves) and attribute that consequence to the internal motives of the part of the patients* [7, emphasis added].

Linehan's suggestion that it is a "cognitive error" to attribute the hurtfulness associated with BPD behaviour to the moral intentions of people with BPD raises the possibility that the *moral deficit model* is based as much in clinician oversight as it is in empirical fact.

In the next subsection, I will explore what the analysis here suggests about effective treatments against BPD. I will suggest that non-moral causes require non-moral treatments, and I will present evidence that DBT is exactly this type of treatment.

### **3.3 What type of treatment is this?**

So far, I have argued that immoral behaviours are clearly an integral part of CBPDs (I thus accept the first step of Charland's *argument from treatment*), but that, at least according to evidence collected from DBT patients, these behaviours arise from non-moral emotional causes (I thus reject the second step of Charland's *argument from treatment*). Turning now to treatment itself, we can ask: is DBT a moral treatment?

Charland's view on the treatment of CBPDs is clear:  
...Cluster B personality disorders are fundamentally moral conditions.  
Consequently, their treatment requires a sort of moral treatment. None of this should be taken to imply that Cluster B disorders cannot or do not admit of treatment using other means. Rather, the point is simply that those other treatment interventions can never be sufficient for complete treatment or recovery. There is a moral line in the sand that pharmacology apparently cannot cross. Only moral treatment can assure a full cure [3:124].

But what exactly is moral treatment? Charland is clear about this as well:  
Strictly speaking, [moral treatment] is not clinical and it is misleading to consider it a professional clinical skill or intervention; rather, it is a moral initiative, undertaken between two moral beings, in the quest for moral consensus on how to behave morally with respect to one another [3:124].

Keeping this in mind, recall Linehan's empirical observations of BPD patients: Borderline and suicidal individuals frequently possess good interpersonal skills in a general sense. The problems arise in the application of these skills to the situations that the patients encounter [7:151].

Given Linehan's clinical observations, can a fully successful treatment of BPD really be, at its core, a "quest for moral consensus on how to behave morally with respect to one another," as Charland suggests? This seems highly implausible. On the contrary, Linehan's experience suggests that BPD patients are fully aware, and even knowledgeable, about moral ways to behave with respect to one another. Consensus has already been reached. Their problem, however, is in the application of this knowledge. Indeed, recall that BPD patients,  
...may be able to describe effective behavioural sequences when discussing another person encountering a problematic situation, but may be completely incapable of

generating or carrying out a similar behavioural sequence when analyzing their own situation. Usually, the problem is that belief patterns and uncontrollable affective responses are inhibiting the application of social skills [7:151].

Thus, rather than focusing on attempting to reach consensus on what constitutes moral behaviour, Linehan suggests that treatment for BPD should take the following form. Of course, she is describing DBT:

Recognition of these emotional regulation difficulties, originating in both biological makeup and inadequate learning experiences, suggests that treatment should focus on the twin tasks of teaching the borderline patient (1) to modulate extreme emotionality and reduce maladaptive mood-dependent behaviours, and (2) to trust and validate her own emotions, thoughts, and activities [7: 62].

It is through focusing on these twin tasks of treating the non-moral emotional dysfunction at the root of BPD, that the sequale of that root – immoral behaviour, among other things – are indirectly reduced. This characterization of the core intentions of DBT is very different than Charland’s characterization of DBT as a sort of moral edification. Charland suggests that the DBT practitioner “plays some sort of moral authority or guiding role”, and that part of this role is the aim “to convince the client to try and be more honest, more truthful, less manipulative, and less resentful and vindictive” [3:124].

On the contrary, Linehan emphasizes that a key trait of the ideal DBT practitioner is the ability to be radically accepting of the patient’s inner state, and to be able to withhold moral judgments of patient behaviours in order to allow the patient to find ways to internally motivate their own behaviour change. She tells us that,

The DBT tenets of observing, mindfulness, and avoidance of judgment are all derived from the study and practice of Zen meditation. The behavioural treatment most similar to DBT in this respect is Hayes’s (1987) contextual psychotherapy. Hayes is a radical behavior therapist who also emphasizes the necessity of behavioural acceptance [7:21].

Overall, these considerations suggest that DBT is not, at root, a moral treatment according to Charland's vision of it.

However, I may be jumping to conclusions here. I am relying heavily on Linehan's descriptions of DBT. Charland has been careful to point out that the "moral aspect present in DBT that is adroitly concealed beneath its clinical description" [3:123]. He suggests that this moral dimension of DBT is hidden because practitioners are not trained to deliver moral treatment, and so this core feature must remain hidden from patient and public view. This is a very plausible argument. It is possible that Linehan's published descriptions of DBT practitioners may simply be leaving out their essential moral guidance qualities.

In light of this possibility, I suggest the following two-step philosophical argument against the view that DBT is a moral treatment. Importantly, this argument does not rely on Linehan's descriptions of practitioners. First, I take it as conceptually necessary that successful treatment of a mental disorder must address the causes of the disorder, and not merely the effects and symptoms resulting from those causes. This is a logical point. Leaving the causes of a disorder intact, while eliminating only its effects, cannot logically result in successful treatment of that disorder. At best, the disorder may enter temporary remission, but it will not be successfully treated until the underlying source of the maladjustment is rectified.

Second, if we accept the first step together with the conclusion of the previous subsection – that the causes of BPD, at least according to DBT, are non-moral deficits – we must conclude that DBT is successful *via* its treatment of non-moral factors. In other words, DBT is not primarily a moral treatment.

This analysis is very important because it has repercussions for who treats CBPDs. Charland wonders:

What kind of professionals, with what kind of training and licensing, if any, should we consider suited to administer the required interventions?...I wonder whether clinically trained therapists and psychiatrists have the requisite skills and

knowledge to conduct the sort of treatment required to ‘cure’ the cluster B disorders. The reason is that ‘moral’ disorders seem to require ‘moral’ treatment, and professional psychologists and psychiatrists are not normally trained for that [4:121].

Charland suggests here that psychologists and psychiatrists are not prepared to treat CBPDs. Instead, one might imagine that a priest, a parent or a friend is better prepared to provide moral guidance than a professional mental health clinician is. However, in contrast to this suggestion, my interpretation of Linehan’s account of DBT makes clear that BPD requires first and foremost treatment of non-moral emotional and cognitive factors. Psychiatrists and psychologists are well suited to carry out this type of treatment.

Yet, if this is the case, then why has clinical treatment been traditionally so ineffective against BPD? As I will explore in the next section, it could be that clinicians have simply been treating BPD using inappropriate models of it and inappropriate intervention strategies. Actually, I will explore evidence that suggest some forms of standard psychotherapy may actually lead to negative iatrogenic effects that exacerbate BPD.

I must consider one final objection here. I may be charged with missing the forest for the trees. An objector may argue that if one is treating the non-moral causes of moral behaviour problems, then one is really engaged in moral treatment. In psychiatry, they may argue, causes and effects come as a single package, and so we must consider them as a single complex disorder unit that is under treatment.

This objection is similar the third objection mentioned in section 2.1. There, the objection was that “moral character” may include values, desires, beliefs, *and* behaviours. Here, the objection is that while causes of BPD may not themselves not be moral, they are part of an overall package that includes immoral behaviour, and as such, the treatment of BPD is moral treatment.

I cannot provide arguments against this objection beyond those that I have already

made about the need to separate disorder causes from disorder symptoms. Thus, if one takes this line of defense against my argument, then at least it should be made clear. This paper should contribute to drawing attention to the need to make this point clear, which should illuminate further scholarship on the issue of whether CBPDs are primarily moral or primarily clinical kinds.

Alas, let us not base our analysis of BPD only on DBT theory and practice. It could be the case that Linehan is simply wrong about the causes underlying BPD. After all, BPD etiology is the theoretical part of the DBT model. Indeed, consider this revealing passage tucked discretely into the end of the third chapter of Linehan's book:

The biosocial theory I am presenting here is speculative. There has been little prospective research to document the application of this approach to the etiology of BPD. Although the theory is in accord with the known literature on BPD, no research has been mounted so far to test the theory prospectively. Thus, the reader should keep in mind that the logic of the biosocial formulation of BPD described in this chapter is based largely on clinical observation and speculation rather than on firm empirical experimentation. Caution is recommended [7:65].

The clinical evidence she is referring to is the immoral behaviour before DBT treatment, and the resolution of that immoral behaviour after DBT treatment. Given a different theoretical etiology, these facts could be consistent with the *moral deficit model*. To assess this possibility, let us look at another therapy that has shown recent clinical efficacy against BPD.

#### **4. Mentalization-Based Treatment**

MBT is an innovative psychodynamic therapy for BPD that was developed largely in reaction to the paucity of effective treatments for BPD. It was established by clinical psychologists Peter Fonagy and Anthony Bateman. In contrast to DBT, which has shown variable long-term treatment effects [eg. 13,14], MBT has shown, in one well controlled study, sustained positive treatment effects eight years after treatment initiation,

and five years after the end of treatment [15]. Levy opines that these findings, ... firmly cement mentalization-based therapy as a viable treatment in the existing armamentarium for borderline personality disorder [8:557].

Given the history of near therapeutic nihilism about BPD apart from the limited success of DBT, what accounts for this nascent shining achievement of MBT?

#### **4.1 Mentalization**

MBT is built upon two theoretical pillars. The first is *mentalization*. According to Fonagy and Bateman,

Mentalization, or better mentalizing, is the process by which we make sense of each other and ourselves, implicitly and explicitly, in terms of subjective states and mental processes [9:11].

Since mentalization is carried out in the context of intimate interpersonal relationships, the second pillar of MBT is Bowlby's attachment theory. Specifically, Fonagy and Bateman submit that,

There is suggestive evidence that borderline patients have a history of disorganized attachment, which leads to problems in affect regulation, attention and self control. It is our suggestion that these problems are mediated through a failure to develop a robust mentalizing capacity [9:12].

Built upon these two pillars, the core deficit of BPD, which immediately suggests the nature of treatment required to alleviate that deficit, is the following:

Our premise is that unstable or reduced mentalizing capacity is a core feature of borderline personality disorder (BPD). Therefore, successful treatment must have mentalization as its focus or at least stimulate development of mentalizing as an epiphenomenon [16:83].

The researchers elaborate on the theory and objectives of MBT here:

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We have argued that persons with borderline personality disorder have an impoverished model of their own and others' mental function... Their schematic, rigid, sometimes extreme ideas about their own and others' states of mind make them vulnerable to powerful emotional storms and apparently impulsive actions, and create profound problems of behavioural and affect regulation... If this is correct, the recovery of the capacity for mentalisation in the context of attachment relationships has to be a primary objective of all psychosocial treatments for borderline personality disorder [17:2].

I will call the etiology of BPD suggested here - a lack of ability to mentalize coupled with an impaired attachment system - the *mentalizing deficit model*. I suggest that this model is consistent with Linehan's view that emotional dysfunction is at the root of BPD. Both DBT and MBT point to similar underlying causes of BPD: impairments in non-moral cognitive and emotional systems (expressed especially in interpersonal contexts), not necessarily in an impaired sense of moral right and wrong. Correspondingly, since MBT and DBT primarily treat non-moral causes, both MBT and DBT are primarily clinical, and not moral, treatments.

To support this interpretation, I call attention to the fact that descriptions of MBT are even more explicitly non-moral than are descriptions of DBT. The focus in MBT is to carefully foster the growth of the patient's mentalizing capacity whilst *actively* avoiding moral education of the patient. This is an important point, so I quote here at length:

The objective is for the patient to find out more about how he thinks and feels about himself and others, how that dictates his responses, and how errors in understanding himself and others lead to actions in an attempt to retain stability and to make sense of incomprehensible feelings. *It is not for the therapist to tell the patient about how he feels, what he thinks, how he should behave, what the underlying reasons are, conscious or unconscious, for his difficulties.*

*We recommend an inquisitive or not-knowing stance.* This is not synonymous with

having no knowledge... When the therapist takes a different perspective to the patient this should be verbalised and explored in relation to the patient's alternative perspective, *without making assumptions about whose viewpoint has greater validity* [16:93, emphasis added].

This explicit avoidance of moralizing is a vital feature of MBT. Again, it is worth quoting the reasoning behind this feature at length:

...those who have a very poor appreciation of their own and others' perception of mind are unlikely to be able to benefit from traditional (particularly insight-oriented) psychological therapies. When presented with a coherent view of mental function in the context of psychotherapy, [BPD patients] are not able to compare the picture offered to them with a self-generated model and may all too often accept alternative perspectives uncritically or reject them wholesale... as overly simplistic and patronising, which in turn fuels a sense of abandonment, feelings of isolation and desperation.

Even focusing on how the patient feels can have its dangers. A person who has little capacity to discern the subjective state associated with anger cannot benefit from being told both that they are feeling angry and the underlying cause of that anger. Such an assertion addresses nothing that is known or can be integrated. It can only be accepted as true or rejected outright, but in neither case is it helpful... Unsurprisingly, this results in more rather than less mental and behavioural disturbance [17:2].

These reflections on BPD, and the recommendations of non-moralizing therapy based on them, stand in stark contrast to Charland's suggestion that,

Among other things, the therapist's aim... is to convince the client to try and be more honest, more truthful, less manipulative, and less resentful and vindictive [3:124].

MBT, thus, presents a very clear challenge to the view that successful treatment of CBPDs requires moral treatment.

Further, Fonagy and Bateman note that common therapeutic mechanisms may underlie both DBT and MBT:

Many aspects of DBT... include important components facilitating mentalization, discussed in slightly different language, e.g., mindfulness, validation, self-states etc. The sole way that MBT considers itself unique in relation to [DBT] is placing mentalization at the epicentre of therapeutic change [16:93].

One of the chief practical advantages of MBT over DBT is that it does not require extensive training to learn to administer. DBT is a highly structured system of therapy that requires much training, case-support, and supervision [7]. In contrast, Bateman and Fonagy stress that many types of therapy and many types of clinicians can be effective against BPD, so long as they include a focus on mentalizing capacity, or at least “stimulate development of mentalizing as an epiphenomenon” [16:83]. The stunning initial success of MBT may partially reflect its easily implementable nature. This success of MBT also suggests that a focus on mentalizing may be the key of successful BPD treatment that was missing from previous strategies. I will explore this idea more in the final subsection.

It is important to admit that though MBT explicitly stresses a non-moralizing treatment style, it still has moral goals like does BDT. For example, the first treatment aim of MBT is, like it is in DBT, to decrease and stabilize suicidal and other therapy-interfering behaviour [10:13]. This moral goal is not surprising, however, for as we saw above, it is logically necessary to achieve moral behaviour change in order to successfully treat BPD. Nonetheless, MBT achieves this goal via administering treatment to the impaired mentalizing capacity, which MBT theory names as the root cause of BPD, and not on administering moral lessons.

Of course, like in the case of DBT, one could still argue that treating non-moral

causes of moral behaviour problems is in fact moral treatment, even if one expressly avoids clothing their therapy in moral lessons. This interpretation is not obviously false, however, it will be harder to take this line with MBT than with DBT, simply given the explicit focus in MBT on steering clear of attempting to morally educate BPD patients.

#### **4.2 Iatrogenic effects**

An interesting, though quite speculative, suggestion that Bateman and Fonagy make is that, based on the MBT theory above, psychotherapy which employs a strong moralizing stance may actually have negative iatrogenic effects on BPD patients:

...some psychosocial treatments practiced currently, and perhaps even more commonly in the past, may have impeded the borderline patient's capacity to recover. *We believe that any therapy approach that moves towards knowing how a patient is, how he should behave and think, and why he is like he is, is likely to be harmful* [16:93, emphasis added].

Interestingly, Fonagy and Bateman cite some neuroscientific evidence that may help explain why the potential for iatrogenic effects exists. Bartels and Zeki found that activation of the normal adult attachment system (which therapy induces) temporarily inhibits the ability for normal adults to mentalize [18]. In light of this empirical fact, when BPD patients, who already have a compromised mentalization system, enter into a therapeutic relationship, their impaired mentalizing capacity may, unfortunately, be exacerbated.

In light of this possibility, Bateman and Fonagy suggest that, Treatment will only be effective to the extent that it is able to enhance the patient's mentalizing capacities without generating too many negative iatrogenic effects as it stimulates the attachment system [10:2].

Striking this delicate balance between providing emotional and cognitive support to BPD patients, while also giving them significant freedom and power to interpret their own and other's mental states and actions, may be the exceedingly elusive key to effective BPD treatment that has evaded so many practitioners.

## 5. Conclusion

The Cluster-B personality disorders have traditionally been difficult conditions to understand, let alone treat. In the face of their clinical obstinacy, some practitioners as well as philosophers have suggested that these conditions may not really be clinical, or medical, conditions at all. Instead, it has been suggested that they may be moral shortcomings, and if so, may require distinctly moral types of intervention to dislodge – perhaps by a pastor instead of a psychiatrist. To assess the validity of this *moral deficit model*, a rich source of data and theory exists in two psychotherapies that have shown recent clinical efficacy against one Cluster B personality disorder that is especially difficult to treat: borderline personality disorder. In this paper, I have argued that both Dialectical Behaviour Therapy and Mentalization-Based Treatment do not support the *moral deficit model* of borderline personality disorder. Accordingly, these treatments, though perhaps more fine-tuned than other forms of psychotherapy, are still squarely clinical treatments.

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