Borderline Personality Disorder At A Glance*

Borderline personality disorder is the most common personality disorder in clinical settings, however, this disorder is often incorrectly diagnosed or underdiagnosed in clinical practice. Borderline personality disorder causes marked distress and impairment in social, occupational, and role functioning, and it is associated with high rates of self-destructive behavior (e.g., suicide attempts) and completed suicide.

The essential feature of borderline personality disorder is a pervasive pattern of instability of interpersonal relationships, affects, and self-image, as well as marked impulsivity. These characteristics begin by early adulthood and are present in a variety of contexts. The core features of borderline personality disorder can also be conceptualized as consisting of a number of psychopathological dimensions (e.g., impulsivity, affective instability).

DIAGNOSTIC CRITERIA FOR BORDERLINE PERSONALITY DISORDER

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:
1) Frantic efforts to avoid real or imagined abandonment
2) A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation
3) Identity disturbance: markedly and persistently unstable self-image or sense of self
4) Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating)a
5) Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior
6) Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)
7) Chronic feelings of emptiness
8) Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)
9) Transient, stress-related paranoid ideation or severe dissociative symptoms

ACUTE TREATMENT

Psychiatric management forms the foundation of treatment for all patients. The primary treatment for borderline personality disorder is psychotherapy, complemented by symptom-targeted pharmacotherapy [I]. In addition, psychiatric management consists of a broad array of ongoing activities and interventions that should be instituted for all patients with borderline personality disorder [I]. Regardless of the specific primary and adjunctive treatment modalities selected, it is important to continue providing psychiatric management throughout the course of treatment. The components of psychiatric management for patients with borderline personality disorder include responding to crises and monitoring for safety, establishing and maintaining a therapeutic framework and alliance, providing education about borderline personality disorder and its treatment,

coordinating treatment provided by multiple clinicians, monitoring progress, and reassessing the effectiveness of the treatment plan.

PRINCIPLES OF TREATMENT SELECTION

Certain types of psychotherapy (as well as other psychosocial modalities) and certain psychotropic medications are effective in the treatment of borderline personality disorder [I]. Although it has not been empirically established that one approach is more effective than another, **clinical experience suggests that most patients with borderline personality disorder will need extended psychotherapy to attain and maintain lasting improvement in their personality, interpersonal problems, and overall functioning** [II]. Pharmacotherapy often has an important adjunctive role, especially for diminution of symptoms such as affective instability, impulsivity, psychotic-like symptoms, and self-destructive behavior [I]. No studies have compared a combination of psychotherapy and pharmacotherapy to either treatment alone, but clinical experience indicates that many patients will benefit most from a combination of these treatments [II].

Focus

Treatment planning should address borderline personality disorder as well as comorbid axis I and axis II disorders, with priority established according to risk or predominant symptoms [I].

Because comorbid disorders are often present and each patient's history is unique, and because of the heterogeneous nature of borderline personality disorder, the treatment plan needs to be flexible, adapted to the needs of the individual patient [I]. Flexibility is also needed to respond to the changing characteristics of patients over time.

Treatment should be a collaborative process between patient and clinician(s), and patient preference is an important factor to consider when developing an individual treatment plan [I].

Treatment by a single clinician and treatment by more than one clinician are both viable approaches. [II]. Treatment by multiple clinicians has potential advantages but may become fragmented; good collaboration among treatment team members and clarity of roles are essential.

PSYCHOTHERAPY

Two psychotherapeutic approaches have been shown in randomized controlled trials to have efficacy: psychoanalytic/psychodynamic therapy and dialectical behavior therapy [I]. The treatment provided in these trials has three key features: weekly meetings with an individual therapist, one or more weekly group sessions, and meetings of therapists for consultation/supervision. No results are available from direct comparisons of these two approaches to suggest which patients may respond better to which type of treatment. Research suggests that substantial improvement may not occur until after approximately 1 year of psychotherapeutic intervention has been provided; many patients require even longer treatment.

Clinical experience suggests that there are a number of common features that help guide the psychotherapist, regardless of the specific type of therapy used [I]. These

features include building a strong therapeutic alliance and monitoring self-destructive and suicidal behaviors. Some therapists create a hierarchy of priorities to consider in the treatment (e.g., first focusing on suicidal behavior). Other valuable interventions include validating the patient's suffering and experience as well as helping the patient take responsibility for his or her actions. Because patients with borderline personality disorder may exhibit a broad array of strengths and weaknesses, flexibility is a crucial aspect of effective therapy.

Other components of effective therapy for patients with borderline personality disorder include managing feelings (in both patient and therapist), promoting reflection rather than impulsive action, diminishing the patient's tendency to engage in splitting, and setting limits on any self-destructive behaviors.

Individual psychodynamic psychotherapy without concomitant group therapy or other partial hospital modalities has some empirical support [II]. The literature on group therapy or group skills training for patients with borderline personality disorder is limited but indicates that this treatment may be helpful [II]. Group approaches are usually used in combination with individual therapy and other types of treatment. The published literature on couples therapy is limited but suggests that it may be a useful and, at times, essential adjunctive treatment modality.

While data on family therapy are also limited, they suggest that a psychoeducational approach may be beneficial [II]. Published clinical reports differ in their recommendations about the appropriateness of family therapy and family involvement in the treatment; family therapy is not recommended as the only form of treatment for patients with borderline personality disorder [II].

Pharmacotherapy and other somatic treatments

Pharmacotherapy is used to treat state symptoms during periods of acute decompensation as well as trait vulnerabilities. Symptoms exhibited by patients with borderline personality disorder often fall within three behavioral dimensions—affective dysregulation, impulsive-behavioral dyscontrol, and cognitive-perceptual difficulties—for which specific pharmacological treatment strategies can be used

OTHER SPECIFIC TREATMENT ISSUES

Attention to risk management issues is important [I]. Risk management considerations include the need for collaboration and communication with any other treating clinicians as well as the need for careful and adequate documentation. Any problems with transference and countertransference should be attended to, and consultation with a colleague should be considered for unusually high-risk patients. Standard guidelines for terminating treatment should be followed in all cases. Psychoeducation about the disorder is often appropriate and helpful. Other clinical features requiring particular consideration of risk management issues are the risk of suicide, the potential for boundary violations, and the potential for angry, impulsive, or violent behavior.

Splitting

The phenomenon of "splitting" signifies an inability to reconcile alternative or opposing

perceptions or feelings within the self or others, which is characteristic of borderline personality disorder. As a result, patients with borderline personality disorder tend to see people or situations in "black or white," "all or nothing," "good or bad" terms. In clinical settings, this phenomenon may be evident in their polarized but alternating views of others as either idealized (i.e., "all good") or devalued (i.e., "all bad"). When they perceive primary clinicians as "all bad" (usually prompted by feeling frustrated), this may precipitate flight from treatment. **When splitting threatens continuation of the treatment, clinicians should be prepared to examine the transference and countertransference and consider altering treatment. This can be done by offering increased support, by seeking consultation, or by otherwise suggesting changes in the treatment**. Clinicians should always arrange to communicate regularly about their patients to avoid splitting within the treatment team (i.e., one clinician or treatment is idealized while another is devalued). Integration of the clinicians helps patients integrate their internal splits.

Boundaries

Clinicians/therapists vary considerably in their tolerance for patient behaviors (e.g., phone calls, silences) and in their expectations of the patient (e.g., promptness, personal disclosures,homework between sessions). It is important to be explicit about these issues, thereby establishing "boundaries" around the treatment relationship and task. It is also important to be consistent with agreed-upon boundaries. Although patients may agree to such boundaries, some patients with borderline personality disorder will attempt to cross them (e.g., request between session contacts or seek a personal, nonprofessional relationship). It remains the therapist's responsibility to monitor and sustain the treatment boundaries

*Adapted from John M. Oldham,et al. Practice Guideline for the Treatment of Patients With Borderline Personality Disorder. American Psychiatric Association, 2001