Borderline personality disorder: Treatment overview

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INTRODUCTION

Borderline personality disorder (BPD) is characterized by instability of interpersonal relationships, self-image, and emotions, and by impulsivity. Patients with BPD often receive mental health treatment [1,2]. The disorder is more widely studied than any other personality disorder [3]. Despite these efforts, patients with BPD continue to suffer considerable morbidity and mortality [4].

First-line treatment for BPD is psychotherapy [5-7]. Adjunctive use of symptom targeted medications has been found to be useful [8].

This topic describes our approach to selecting treatments for BPD. The epidemiology, clinical features, course, assessment, and diagnosis of BPD are reviewed separately. Psychotherapy for BPD is also reviewed separately. Pharmacotherapy for personality disorders is also reviewed separately, as are approaches to the therapeutic relationship in patients with personality disorders. (See "Borderline personality disorder: Epidemiology, pathogenesis, clinical features, course, assessment, and diagnosis" and "Borderline personality disorder: Psychotherapy" and "Personality disorders: Overview of pharmacotherapy" and "Approaches to the therapeutic relationship in patients with personality disorders".)

GENERAL PRINCIPLES

Management of borderline personality disorder is guided by principles derived from our and others' clinical experience [5]:

- Evaluate the accuracy of all psychiatric diagnoses, as patients with personality disorders are sometimes misdiagnosed. (See "Borderline personality disorder: Epidemiology, pathogenesis, clinical features, course, assessment, and diagnosis", section on 'Diagnosis'.)
- Psychotherapy and pharmacotherapy may be delivered comprehensively by a single clinician [9] or can be delivered collaboratively by separate clinicians. (See "Collaboration between prescribing physicians and psychotherapists in mental health care".)
- Develop and maintain a therapeutic alliance. (See "Approaches to the therapeutic relationship in patients with personality disorders".)
- Interact with patients in an active and empathic manner, and validate their experiences.
- Encourage patients to take responsibility for their actions and problems.
- Maintain regular appointments that patients are expected to keep.
- Establish clear boundaries with respect to the treatment relationship and patient behaviors.
- Set limits when necessary to maintain these boundaries.

INITIAL TREATMENT

Choosing psychotherapy — For individuals with borderline personality disorder (BPD), we suggest first-line treatment with psychotherapy. In our clinical experience, any of these psychotherapies could be used first line:

- Dialectical behavior therapy (DBT)
- Mentalization-based therapy
- Transference-focused therapy
- "Good psychiatric management"
- Cognitive and behavioral therapies
- Schema-focused therapy

Systematic review and meta-analysis of clinical trials have found these psychotherapies collectively to be effective for multiple BPD outcomes compared with control interventions

[10,11]. Few trials directly compare these therapies; however, our clinical experience leads us to conclude that all of these psychotherapies have comparable efficacy for BPD [12-14]. Psychotherapies for BPD and their efficacy are discussed elsewhere. (See "Borderline personality disorder: Psychotherapy".)

DBT for specific patients — In our clinical experience, one should consider dialectical behavior therapy (DBT) for the most regressed patients or for those with high levels of self-destructiveness. This is because DBT focuses on increasing coping skills and tolerance of unwanted or previously intolerable affect, and much self-destructive behavior and acting out behavior appears to be triggered by being overwhelmed by affect (emotion dysregulation). DBT directly builds up greater resistance to being overwhelmed by affect and provides practical suggestions, especially through its group therapy component, on how to better manage these periods.

After behavior and safety have stabilized, a less structured, more insight-oriented or interpersonally-focused approach, along the lines of mentalization-based or transference-focused therapy, or “good psychiatric management,” may yield the best results. Patients may benefit from a sequencing of psychotherapies (or a shift in emphasis within a psychotherapy) based on the patient’s clinical status and/or phase in an evolving treatment.

Addressing co-occurring conditions — BPD co-occurs with a number of psychiatric disorders at a higher rate compared with the general population, raising a number of treatment issues. (See "Borderline personality disorder: Epidemiology, pathogenesis, clinical features, course, assessment, and diagnosis", section on 'Comorbidities'.)

Depression and anxiety — In patients with BPD and a co-occurring mood or anxiety disorder, both diagnoses should be subjects of clinical attention, but treatment should focus principally on BPD. Research and our clinical experience suggest that effective treatment of BPD, rather than the co-occurring disorder, is more likely to lead to remission or improvement of both disorders [15].

As an example, the affect of depression as presented by patients with BPD does not always (or even often) represent a major depressive episode. We should be cautious about prescribing more and higher doses of antidepressant medication to treat subthreshold symptoms when there is little evidence to support drug efficacy. This does not mean that the comorbid diagnosis should be ignored. Comorbid psychiatric disorders with effective pharmacologic interventions can be treated, but not to the exclusion of BPD treatment.

Panic attacks and insomnia — Issues such as overwhelming and immobilizing anxiety or panic attacks, and sleep disturbance, can be addressed with medication, although emphasis

should be given to medications are not subject to misuse or physiologic dependence, and are not lethal in overdose. Nonpharmacologic practices to promote sleep hygiene and other behavioral interventions can also be tried. (See "Management of panic disorder with or without agoraphobia in adults", section on 'SSRIs as preferred initial pharmacotherapy' and "Cognitive behavioral therapy for insomnia in adults".)

Substance use — Treatment of BPD is very difficult in patients with ongoing substance use. Psychoeducation and motivational interviewing can be useful approaches. In patients with a co-occurring substance use disorder, treatment of the substance use disorder should take precedence over BPD (other than for issues of safety). Physiologically dependent patients, if willing, should undergo medically supervised withdrawal followed by maintenance treatment. (See "Substance use disorders: Motivational interviewing" and "Continuing care for addiction: Implementation" and "Opioid withdrawal: Medically supervised withdrawal during treatment for opioid use disorder" and "Management of moderate and severe alcohol withdrawal syndromes".)

Other co-occurring mental disorders — Other mental disorders whose treatment should be prioritized in patients with BPD include bipolar I disorder, early-onset complex posttraumatic stress disorder, and anorexia nervosa [4]. Co-occurring antisocial personality disorder makes successful treatment of BPD unlikely.

Matching clinical status to level of care — Patients with BPD should be evaluated for risks to safety at an initial presentation and at subsequent encounters:

- Severity of signs and symptoms
- Presence of violent or potentially lethal ideation directed at self or others
- Ability to control dangerous impulses
- Presence of comorbid conditions (eg, depression, substance use disorder, eating disorder, or the medical consequences of impulsive behavior)
- Recent psychosocial stressors

While much of treatment for BPD will be delivered in an outpatient setting, an evaluation can help identify patients who may intermittently require a hospital- or intermediate-level of care to maintain the patient's safety (eg, an acutely suicidal BPD patient without a good safety plan). An intermediate level of care has the capacity for around the clock treatment and monitoring; names of care at this level can include crisis or respite programs, residential care, intensive outpatient treatment, or brief inpatient hospitalization.

Some BPD patients have chronic suicidal ideation. With these patients, the negative effects of hospitalization should also be considered. The patient can regress and become even more passive or suicidal in the hospital. The patient may be treated with contempt in clinical settings where BPD is poorly understood (BPD is stigmatized in some mental health settings). The patient may be overmedicated by clinicians who, for example, are unaware that BPD patients can experience transient psychotic symptoms during periods of high stress that may resolve without antipsychotic medication or respond to lower antipsychotic doses that those used for psychotic disorders.

Other elements of the patient's assessment can be used to adjust the level or intensity of ambulatory care to match the patient's clinical status and treatment needs. Although the availability of specific levels of care vary widely geographically, ambulatory care can range from individual weekly visits, to intensive outpatient programs with multiple visits per week, to partial hospitalization programs (or "day treatment"). These assessments include:

- Level of functioning at home and work
- Current social supports
- Coping strategies and behaviors
- Personal strengths and weaknesses
- Goals for treatment

Mainly provided in a group setting, treatment in a partial hospital program focuses principally on reducing harmful and self-destructive behaviors, including substance misuse, and improving coping skills. Partial hospitalization is useful when a patient appears to be deteriorating, but the symptoms are not significant enough to require hospital care. Partial hospital programs, which typically provide treatment weekdays up to 20 hours weekly, may or may not be covered by health insurance in the United States.

PERSISTENT IMPAIRING SYMPTOMS

Symptom-focused treatment — For patients with borderline personality disorder (BPD) who continue to experience severe, impairing symptoms despite receiving evidence-based psychotherapy, we suggest adjunctive, symptom-focused medication treatment. However, evidence supporting the efficacy of pharmacotherapy for BPD is limited [16,17]. Given the limited data on its effectiveness, we moderate our expectations for pharmacologic treatment.

For example, in a meta-analysis including 21 trials and 1768 individuals with BPD, neither second-generation antipsychotics, anticonvulsants, nor antidepressants were able to

consistently reduce the overall severity of BPD as measured by the Zanarini Rating Scale for Borderline Personality Disorder [16]. Nevertheless, anticonvulsants improved specific symptoms such as anger, aggression, and affective lability in single studies while second-generation antipsychotics improved some measures of general psychopathology (ie, the Symptom Checklist 90-Revised or the Clinical Global impression scale) versus placebo. However, the quality of the evidence was rated as low.

We use the framework outlined below to categorize symptoms and select treatment.

Symptom domains — Identification of specific symptom domains has helped to conceptualize a framework for pharmacologic management of individuals with BPD. Meta-analysis of clinical trials of psychotropic medications, including low-dose antipsychotics, mood stabilizers, and antidepressants, have been used to identify the most effective drug classes for treating each of the symptom domains seen in patients with BPD [8]. The symptom domains include:

- Cognitive-perceptual symptoms
- Impulsive-behavioral dyscontrol
- Affective dysregulation

Cognitive-perceptual symptoms — Cognitive-perceptual symptoms seen in BPD can include dissociation, disturbed identity, paranoid ideation, and hallucinations. Meta-analyses have found that low-dose antipsychotic drugs are more effective for disruptive stress-related, cognitive-perceptual experiences compared with antidepressants or mood stabilizers [8]. (See "Personality disorders: Overview of pharmacotherapy", section on 'Cognitive and perceptual disturbances'.)

Impulsive-behavioral dyscontrol — Self-injury, promiscuity, recklessness, gambling, binge eating, and interpersonal hostility and aggression are examples of impulsivity and behavioral dyscontrol that may be seen in BPD. Meta-analyses have found that mood stabilizers are more effective for impulsivity and behavioral dyscontrol compared with antidepressants or antipsychotics [8]. (See "Personality disorders: Overview of pharmacotherapy", section on 'Impulsivity or behavioral dyscontrol'.)

Affective dysregulation — Symptoms of affective dysregulation seen in BPD can include depressed mood or dysphoria, mood lability, anxiety, and anger. Meta-analyses have found that mood stabilizers and low-dose antipsychotic drugs are more effective for affective dysregulation compared with antidepressants [8]. (See "Personality disorders: Overview of pharmacotherapy", section on 'Affective dysregulation'.)

Medication dosing, side effects, and general principles guiding pharmacotherapy in patients with personality disorders are described separately. (See "Personality disorders: Overview of pharmacotherapy".)

SUICIDALITY

Suicidal threats, gestures, and attempts are common manifestations of borderline personality disorder (BPD) [18]. All suicidal ideations and threats should be taken seriously. Principles of management of suicidality in patients with BPD are briefly discussed below [5]:

- BPD patients should be assessed carefully for acute and chronic suicidality, even when nonsuicidal self-injury (NSSI) is suspected
- Take all suicidal ideation and threats and NSSI seriously
- Understand that a “contract for safety” does not obviate the need for a comprehensive clinical evaluation
- Address chronic suicidality in therapy
- Take action for acute suicidality, such as hospitalization
- Involve family members or significant others when clinically appropriate
- Consult a colleague if acute suicidality is not responding to treatment

Further discussion of assessment, risk factors, evaluation, and management of suicidal ideation and behavior in BPD and a more general population can be found elsewhere. (See "Suicidal ideation and behavior in adults" and "Borderline personality disorder: Epidemiology, pathogenesis, clinical features, course, assessment, and diagnosis", section on 'Suicidality'.)

MONITORING

Patients with borderline personality disorder (BPD) should be systematically monitored over their course of treatment, with serial assessment of their symptoms, functioning, safety, medication adherence, and side effects. The Zanarini Rating Scale for Borderline Personality Disorder, which assesses the severity of BPD symptoms based on the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) criteria, can be used for standardized, quantitative assessment [19]. Changes in the patient’s clinical status may necessitate changes to their treatment plan.

SPECIAL CONSIDERATIONS

Some of the challenges clinicians face in treating patients with borderline personality disorder (BPD) stem from their patients' unstable and intense interpersonal characteristics and fragile sense of self [4]. These characteristics may become apparent, and directed at the clinician, in the evaluation and during treatment. (See "Borderline personality disorder: Epidemiology, pathogenesis, clinical features, course, assessment, and diagnosis".)

Individuals with BPD typically have unstable and conflicted relationships, and alternate between overinvolvement with others and social withdrawal. Patients can become deeply involved and dependent on some individuals, including therapists, but they can become manipulative and demanding when they feel that their needs are not met. Patients have dramatic shifts in their views towards people with whom they are emotionally involved, leading them to idealize these individuals when they feel that their needs are being met and to devalue them when they feel disappointed, neglected, or uncared for (referred to as "splitting").

Patients have difficulty recognizing the feelings and needs of other individuals and are hypersensitive to social threat, particularly real or perceived interpersonal rejection. Patients also fear abandonment by others and go to great lengths to avoid abandonment, whether real or imagined, by, for example, showing provocative behaviors such as clinginess, threatening, or demanding behavior.

Individuals with BPD have markedly impoverished, poorly developed, or unstable self-image that is often associated with a chronic feeling of emptiness. Patients also have low self-esteem, are prone to self-criticism and feelings of shame, and can harbor self-contempt or self-hatred. Personal goals, aspirations, values, and career plans are inconsistent, frequently change, and are pursued without conviction.

Lack of a stable sense of self and self-direction can put a strain on the therapeutic process as the patient's goals and expectations for treatment shift. Patients can also experience disturbed cognition, such as transient paranoid ideation or dissociative symptoms, when under stress. Emotional intensity, anger, neediness, demanding behavior, and tendencies to either overvalue or devalue the clinician should be anticipated during evaluations of patients with borderline personality pathology [20].

Patients with BPD can be so intensely demanding and challenging to treat that clinicians may "burn out" and may desire to terminate the treatment. One way to avoid burn out is to assemble a team of clinicians to treat these patients, rather than trying to do so individually.

Clinicians can seek supervision from a more experienced colleague or participate in a consultation group for support and clinical guidance.

Regular communication is required when multiple clinicians treat a patient with BPD [5,7].

Collaboration among clinicians can minimize “splitting” and facilitate the provision of coordinated, effective care. Ongoing discussion among members of the treatment team can also help clinicians manage clinical issues such as countertransference (ie, negative thoughts and feelings on the part of the clinician directed at the patient) that they may experience in the course of treatment.

When there are multiple clinicians involved in the treatment of the patient, agreement needs to be reached as to who is principally following what symptoms or behaviors, particularly suicidality/self-injury, substance use, activities of daily living, and medication adherence and side effects.

Many of these principles are discussed in detail separately. (See "Collaboration between prescribing physicians and psychotherapists in mental health care" and "Approaches to the therapeutic relationship in patients with personality disorders", section on 'Borderline'.)

SOCIETY GUIDELINE LINKS

Links to society and government-sponsored guidelines from selected countries and regions around the world are provided separately. (See "Society guideline links: Personality disorders".)

SUMMARY AND RECOMMENDATIONS

- **Initial treatment** – We recommend an evidence-based psychotherapy as first-line treatment for patients with borderline personality disorder (BPD) (**Grade 1B**). The optimal duration of psychotherapy is not known, but patients often require many months to years of treatment. (See 'Initial treatment' above and "Borderline personality disorder: Psychotherapy".)

- **Choosing psychotherapy** – Based on clinical trial results and limitations, as well as our clinical experience, we consider the psychotherapies for BPD below to be comparably effective. Their availability varies geographically. Selection among them can be based on their availability locally and patient preference. (See 'Choosing psychotherapy' above and "Borderline personality disorder: Psychotherapy".)

- Dialectical behavior therapy (DBT)
- Mentalization-based therapy
- Transference-focused therapy
- "Good psychiatric management"
- Cognitive and behavioral therapies
- Schema-focused therapy

- **DBT for specific patients** – We typically prefer DBT for the most regressed patients or for those with high levels of self-destructiveness. DBT focuses on increasing coping skills and tolerance of unwanted or previously intolerable affect. Many self-destructive and acting out behaviors appear to be triggered by being overwhelmed by affect (ie, emotion dysregulation). (See 'DBT for specific patients' above.)

- **Addressing co-occurring conditions** – BPD co-occurs with a number of psychiatric disorders at a higher rate compared with the general population. (See 'Addressing co-occurring conditions' above.)

  In patients with BPD and a co-occurring mood or anxiety disorder, while both disorders are the subject of clinical attention, our preference is to focus the treatment principally on BPD. Research and our clinical experience suggest that effective treatment of BPD, rather than the co-occurring disorder, is more likely to lead to remission or improvement of both disorders. (See 'Depression and anxiety' above.)

  In patients with a co-occurring substance use disorder, our preference is to prioritize treatment of the substance use disorder over BPD (other than for issues of safety). We treat physiologically dependent patients with medically supervised withdrawal (if they are willing) followed by maintenance treatment. We find that psychoeducation and motivational interviewing are also useful approaches for treating individuals with these co-occurring disorders. (See 'Substance use' above.)

- **Symptom-focused treatment** – For patients who continue to experience severe, impairing BPD symptoms despite receiving evidence-based psychotherapy, we favor symptom-focused adjunct medication treatment (see 'Symptom-focused treatment' above):

  - **Cognitive-perceptual symptoms** – For individuals with BPD with disruptive, stress-related, cognitive-perceptual experiences (such as dissociation, disturbed identity, paranoid ideation, and hallucinations), we suggest treatment with a low-dose, second-generation antipsychotic rather than an antidepressant or mood stabilizing drug

(**Grade 2B**). (See 'Cognitive-perceptual symptoms' above and "Personality disorders: Overview of pharmacotherapy", section on 'Cognitive and perceptual disturbances'.)

- **Impulsive-behavioral dyscontrol** – For individuals with BPD with severe impulsivity or behavioral dyscontrol (such as interpersonal hostility and aggression, self-injury, recklessness), we suggest treatment with a mood stabilizer rather than an antidepressant or antipsychotic drug (**Grade 2B**). (See 'Impulsive-behavioral dyscontrol' above and "Personality disorders: Overview of pharmacotherapy", section on 'Impulsivity or behavioral dyscontrol'.)

- **Affective dysregulation** – For individuals with BPD with severe affective dysregulation (such as depressed mood or dysphoria, mood lability, anxiety, and anger), we suggest first-line treatment with a mood stabilizer rather than an antidepressant (**Grade 2B**). A low-dose antipsychotic would be a reasonable alternative. (See 'Affective dysregulation' above and "Personality disorders: Overview of pharmacotherapy", section on 'Affective dysregulation'.)

- **Suicidality** – Suicidal threats, gestures, and attempts are common manifestations of BPD. All suicidal ideations and threats should be taken seriously. (See 'Suicidality' above.)

- **Special considerations** – Some of the challenges clinicians face in treating patients with BPD stem from their patients' unstable and intense interpersonal characteristics and fragile sense of self. These characteristics may become apparent, and directed at the clinician, in the evaluation and during treatment. (See 'Special considerations' above.)

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