TREATING BORDERLINE PERSONALITY DISORDER

A Quick Reference Guide

Based on *Practice Guideline for the Treatment of Patients With Borderline Personality Disorder,* originally published in October 2001. A guideline watch, summarizing significant developments in the scientific literature since publication of this guideline, may be available in the Psychiatric Practice section of the APA web site at www.psych.org.

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Statement of Intent

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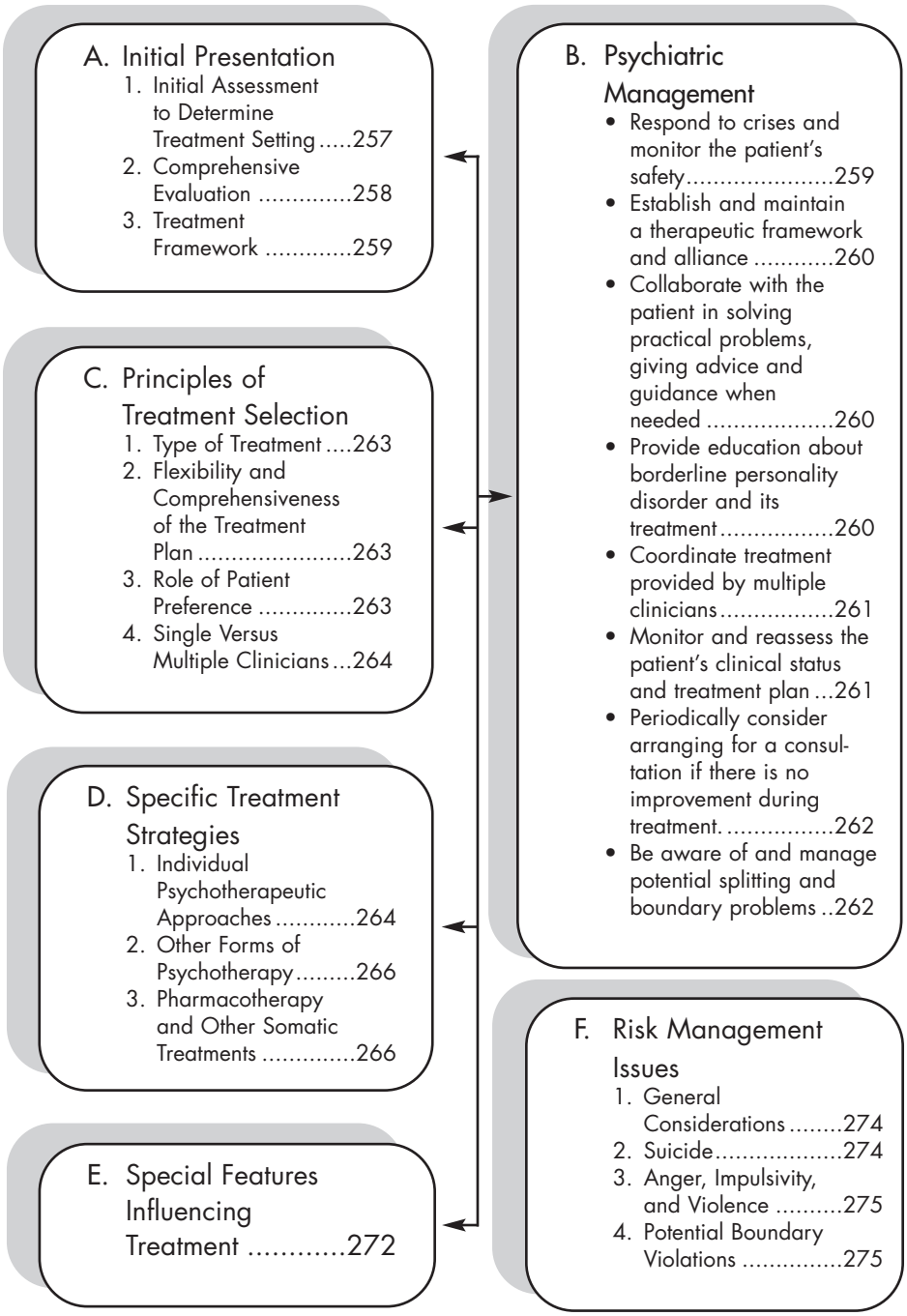
The development of the APA Practice Guidelines and Quick Reference Guides has not been financially supported by any commercial organization. For more detail, see APA's "Practice Guideline Development Process," available as an appendix to the compendium of APA practice guidelines, published by APPI, and online at http://www.psych.org/psych_pract/treatg/pg/prac_guide.cfm.

OUTLINE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A. Initial Presentation

1. Initial Assessment to Determine Treatment Setting

Consider *partial hospitalization* (or brief inpatient hospitalization if partial hospitalization is not available) if any of the following are present:

- Dangerous impulsive behavior that cannot be managed with outpatient treatment
- Deteriorating clinical picture related to nonadherence to outpatient treatment
- Complex comorbidity that requires more intensive clinical assessment of treatment response
- Symptoms that are unresponsive to outpatient treatment and that are of sufficient severity to interfere with work, family life, or other significant domains of functioning

Consider *brief inpatient hospitalization* if any of the following are present:

- Imminent danger to others
- Loss of control of suicidal impulses or serious suicide attempt
- Transient psychotic episode associated with loss of impulse control, impaired judgment, or both
- Symptoms that are unresponsive to outpatient treatment and partial hospitalization and that are of sufficient severity to interfere with work, family life, or other significant domains of functioning

1. Initial Assessment to Determine Treatment Setting *(continued)*

Consider *extended inpatient hospitalization* if any of the following are present:

- Persistent, severe suicidality or self-destructiveness
- Nonadherence to outpatient or partial hospital treatment
- Comorbid refractory axis I disorder (e.g., eating disorder, mood disorder) that is potentially life threatening
- Comorbid substance dependence or abuse that is severe and unresponsive to outpatient treatment or partial hospitalization
- Continued risk of assaultive behavior toward others despite brief hospitalization
- Symptoms of sufficient severity to interfere with functioning and work or family life and that are unresponsive to outpatient treatment and partial hospitalization or brief hospitalization

2. Comprehensive Evaluation

Follow initial assessment with a more comprehensive evaluation that considers a wide range of domains and issues, including

- Presence of comorbid disorders
- Degree and types of functional impairment
- Intrapsychic conflicts and defenses
- Developmental progress and arrests
- Adaptive and maladaptive coping styles
- Psychosocial stressors and strengths in the face of stressors

(See also APA's *Practice Guideline for Psychiatric Evaluation of Adults*.)

Consider additional sources of information (e.g., medical records, informants who know the patient well) in the assessment process because of patient denial and the ego-syntonicity of personality traits and behaviors.

3. Treatment Framework

Establish a clear treatment framework (e.g., a treatment contract) with explicit agreements about the following:

- Goals of treatment sessions (e.g., symptom reduction, personal growth, improvement in functioning)
- When, where, and with what frequency sessions will be held
- A plan for crises
- Clarification of the clinician's after-hours availability
- Fees, billing, and payment

B. Psychiatric Management

The primary treatment for borderline personality disorder is psychotherapy, which may be complemented by symptom-targeted pharmacotherapy. Throughout the course of treatment, it is important to provide psychiatric management as follows:

Respond to crises and monitor the patient's safety.

- Evaluate self-injurious or suicidal ideas.
- Assess the potential dangerousness of behaviors, the patient's motivations, and the extent to which the patient can manage his or her safety without external interventions.
- Reformulate the treatment plan as appropriate.
- Consider hospitalization if the patient's safety is judged to be at serious risk.

B. Psychiatric Management *(continued)*

Establish and maintain a therapeutic framework and alliance.

- Recognize that patients with borderline personality disorder have difficulty developing and sustaining trusting relationships.
- Ascertain that the patient agrees with and explicitly accepts the treatment plan.
- Establish and reinforce an understanding about respective roles and responsibilities regarding the attainment of treatment goals.
- Encourage patients to be actively engaged in the treatment, both in their tasks (e.g., monitoring medication effects or noting and reflecting on their feelings) and in the relationship (e.g., disclosing reactions to or wishes toward the clinician).
- Focus attention on whether the patient understands and accepts what the psychiatrist says, and whether the patient feels understood and accepted.

Collaborate with the patient in solving practical problems, giving advice and guidance when needed.

Provide education about borderline personality disorder and its treatment.

- Familiarize the patient with the diagnosis, including its expected course, responsiveness to treatment, and, when appropriate, known pathogenic factors.
- Provide ongoing education about self-care (e.g., safe sex, potential legal problems, sleep, and diet) if appropriate.
- Consider psychoeducation for families or others who live with patients.

Coordinate treatment provided by multiple clinicians.

- Establish clear role definitions, plans for crisis management, and regular communication among the clinicians.
- Determine which clinician is assuming primary overall responsibility. This clinician will
  - serve as a gatekeeper for the appropriate level of care,
  - oversee family involvement,
  - lead decision making regarding which treatment modalities are useful or should be changed or discontinued,
  - help assess the impact of medications, and
  - monitor the patient's safety.

Monitor and reassess the patient's clinical status and treatment plan.

- Be alert for declines in function.
  - Regressive phenomena may arise if the patient believes he or she no longer needs to be as responsible for self-care.
  - Declines in function are likely to occur during reductions in the intensity or amount of support.
  - If declines during exploratory therapy are sustained, consider shifting treatment focus from exploration to other psychotherapeutic and educational strategies.
- Critically examine apparent medication "breakthroughs" (i.e., sustained return of symptoms that had remitted apparently because of medications).
  - Consider whether breakthroughs are transitory, reactive moods in response to an interpersonal crisis.
  - Avoid frequent medication changes in pursuit of improving transient mood states.
- Consider introducing changes in treatment if the patient fails to show improvement in targeted goals by 6 to 12 months.
- Consider consultation if the patient continues to do poorly after treatment is modified.

B. Psychiatric Management *(continued)*

Periodically consider arranging for a consultation if there is no improvement (e.g., less distress, more adaptive behaviors, greater trust) during treatment.

A low threshold for seeking consultation should occur in the presence of any of the following:

- High frequency of countertransference reactions and medicolegal liability complications
- High frequency of complicated multiclinician, multimodality treatments
- High level of inference, subjectivity, and life-and-death significance involved in clinical judgments

Be aware of and manage potential splitting and boundary problems.

- If splitting threatens continuation of the treatment, consider altering treatment (e.g., increasing support, seeking consultation).
- To avoid splitting within the treatment team, facilitate communication among team members.
- Be explicit in establishing "boundaries" around the treatment relationship and task.
- Maintain consistency with agreed-on boundaries.
- Be aware that it is the therapist's responsibility to monitor and sustain the treatment boundaries.
- In the event of a boundary crossing,
  - explore the meaning of the boundary crossing;
  - restate expectations about the boundary and rationale; and
  - if the boundary crossing continues, employ limit setting.
- Making exceptions to the usual treatment boundaries may signal the need for consultation or supervision.
- Sexual interaction with a patient is always unethical; if it occurs, the patient should be immediately referred to another therapist. The therapist involved in the boundary violation should seek consultation or personal psychotherapy.

C. Principles of Treatment Selection

1. Type of Treatment

- Most patients will need extended psychotherapy to attain and maintain lasting improvement in their personality, interpersonal problems, and overall functioning.
- Pharmacotherapy often has an important adjunctive role, especially for diminution of symptoms such as affective instability, impulsivity, psychotic-like symptoms, and self-destructive behavior.
- Many patients will benefit most from a combination of psychotherapy and pharmacotherapy.

2. Flexibility and Comprehensiveness of the Treatment Plan

- 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 symptomatology.
- The treatment plan must be flexible, adapted to the needs of the individual patient.
- The plan also must respond to the changing characteristics of the patient over time.

3. Role of Patient Preference

- Discuss the range of treatments available for the patient's condition and what the psychiatrist recommends.
- Elicit the patient's views and modify the plan to the extent feasible to take these views and preferences into account.

4. Single Versus Multiple Clinicians

- Both are viable approaches.
- Treatment by multiple clinicians has potential advantages but may become fragmented.
- Good collaboration of the treatment team and clarity about roles and responsibility are essential.
- The effectiveness of single versus multiple clinicians should be monitored over time and changed if the patient is not improving.

D. Specific Treatment Strategies

1. Individual Psychotherapeutic Approaches

Two psychotherapeutic approaches have been shown to have efficacy: psychoanalytic/psychodynamic therapies and dialectical behavior therapy. The key features shared by these approaches suggest that the following can help guide the psychiatrist treating a patient with borderline personality disorder, regardless of the specific type of therapy used:

Expect treatment to be long-term.
Substantial improvement may not occur until at least 1 year of treatment, and many patients require longer treatment.

Create a hierarchy of priorities to be considered in the treatment (e.g., first focus on suicidal behavior).
For examples, see Figure 1 in APA's *Practice Guideline for the Treatment of Patients With Borderline Personality Disorder.*

Monitor self-destructive and suicidal behaviors.

Build a strong therapeutic alliance that includes empathic validation of the patient's suffering and experience.

Help the patient take appropriate responsibility for his or her actions.
- Minimize self-blame for past abuse.
- Encourage responsibility for avoiding current self-destructive patterns.
- Focus interventions more on the here and now than on the distant past.

Use a flexible strategy, depending on the current situation.
- When appropriate, offer interpretations to help develop insight.
- At other times, it may be more therapeutic to provide validation, empathy, and advice.

Appropriately manage intense feelings engendered in both the patient and the therapist.
- Consider the use of professional supervision and consultation.
- Also consider personal psychotherapy.

Promote reflection rather than impulsive action.
- Promote self-observation to generate a greater understanding of how behaviors may originate from internal motivations and affect states.
- Encourage thinking through the consequences of actions.

Diminish splitting.
- Help the patient integrate positive and negative aspects of self and others.
- Encourage recognition that perceptions are representations rather than how things are.

Set limits on the patient's self-destructive behaviors and, if necessary, convey the limitations of the therapist's capacities (e.g., spell out minimal conditions necessary for therapy to be viable).

2. Other Forms of Psychotherapy

Group therapy may be helpful but offers no clear advantage over individual therapy.

- Group therapy is usually used in combination with individual therapy.
- Relatively homogeneous groups are recommended. Exclude from groups patients with antisocial personality disorder, untreated substance abuse, or psychosis.

Couples therapy may be a useful adjunctive modality but is not recommended as the only form of treatment for patients with borderline personality disorder.

Family therapy is most helpful when the patient has significant involvement with family.

- Whether to work with the family should depend on family pathology, strengths, and weaknesses.
- Family therapy is not recommended as the only form of treatment for patients with borderline personality disorder.

3. Pharmacotherapy and Other Somatic Treatments

Principles for choosing specific medications include the following:

- Treatment is symptom specific, directed at particular behavioral dimensions.
- Affective dysregulation and impulsivity/aggression are risk factors for suicidal behavior, self-injury, and assaultiveness and are given high priority in selecting pharmacological agents.
- Medication targets both acute symptoms (e.g., anger treated with dopamine-blocking agents) and chronic vulnerabilities (e.g., temperamental impulsivity treated with serotonergic agents).

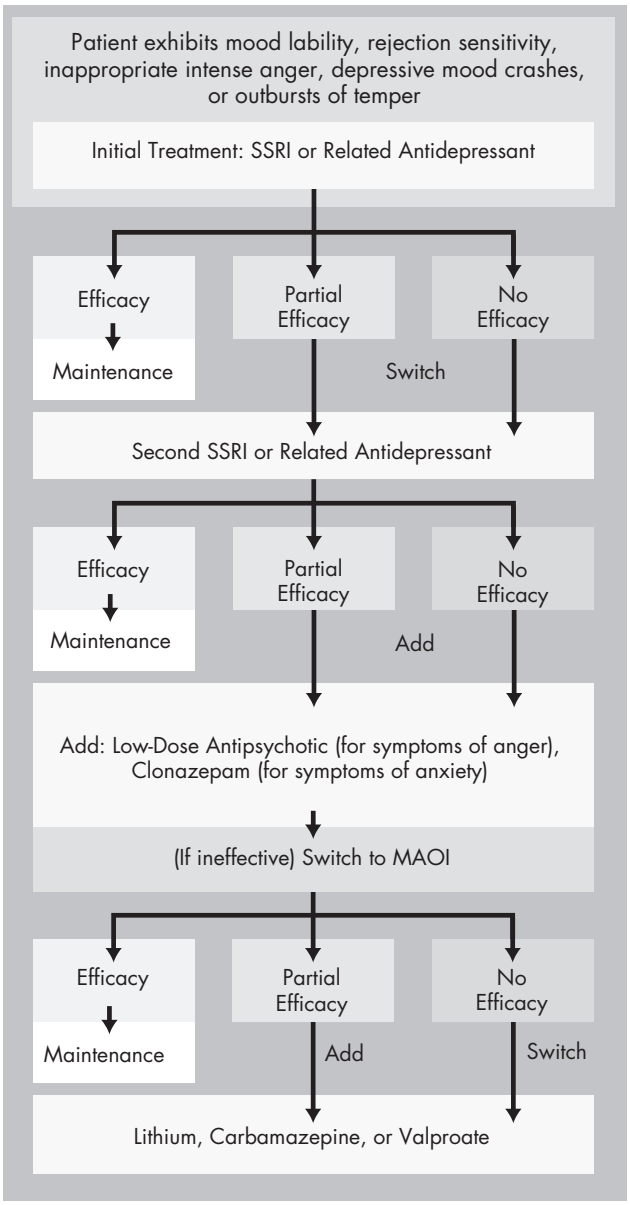
Symptoms to be targeted

Affective dysregulation symptoms (see Figure 1, p. 268)

Treat initially with a selective serotonin reuptake inhibitor (SSRI). A reasonable trial is at least 12 weeks.

- Be cautious about discontinuing successful treatment, especially if the patient has failed to respond to prior medication trials.
- If response is suboptimal, switch to a different SSRI or a related antidepressant.
- Consider adding a benzodiazepine (especially clonazepam) when affective dysregulation presents as anxiety.
- For disinhibited anger coexisting with other affective symptoms, SSRIs are the treatment of choice.
- For severe behavioral dyscontrol, consider adding low-dose antipsychotics.
- Monoamine oxidase inhibitors (MAOIs) are effective but are not a first-line treatment because of the risk of serious side effects and concerns about nonadherence with dietary restrictions.
- Mood stabilizers (lithium, valproate, carbamazepine) are also a second-line treatment (or augmentation treatment).
- Consider electroconvulsive therapy (ECT) for comorbid severe axis I depression refractory to pharmacotherapy.

FIGURE 1. Psychopharmacological Treatment of Affective Dysregulation Symptoms in Patients With Borderline Personality Disorder



3. Pharmacotherapy and Other Somatic Treatments *(continued)*

Symptoms to be targeted *(continued)*

Impulsive-behavioral symptoms (see Figure 2, p. 270)

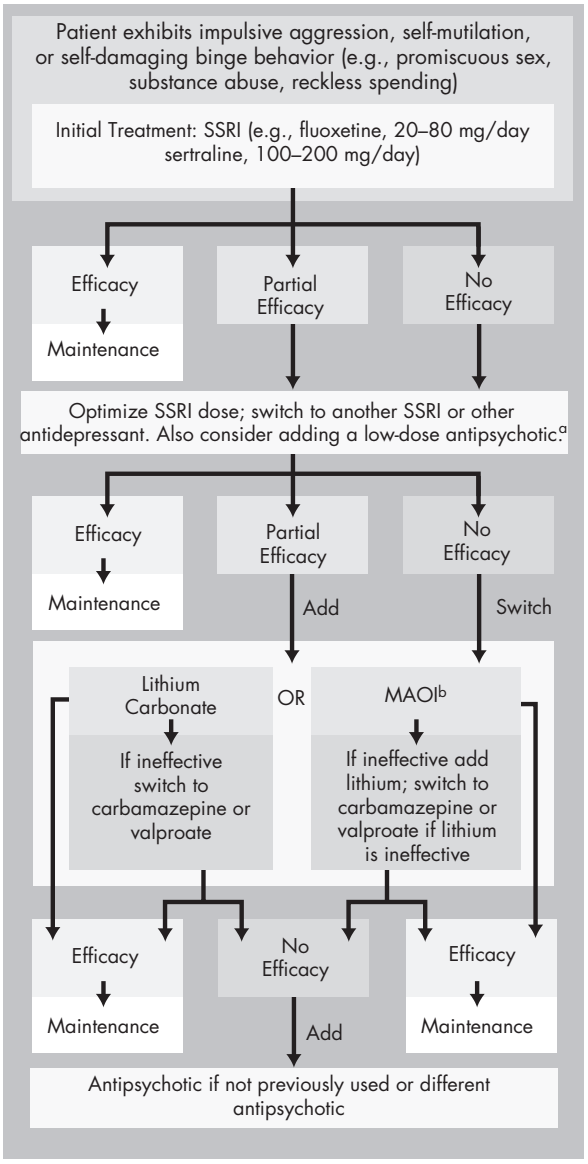
SSRIs are the treatment of choice.

- If a serious threat to the patient's safety is present, consider adding a low-dose antipsychotic to the SSRI. Onset of action is often within hours.
- If an SSRI is ineffective, consider another SSRI or another class of antidepressant.
- If the patient shows partial response to an SSRI, adding lithium may enhance the effectiveness of the SSRI.
- If an SSRI is ineffective, switching to an MAOI may be considered after an appropriate drug washout period.
- Consider valproate, carbamazepine, and second-generation (atypical) antipsychotics. There is widespread use of these agents despite limited data.
- Clozapine may be warranted after other treatments have failed.

Cognitive-perceptual symptoms (see Figure 3, p. 271)

- Low-dose antipsychotics are the treatment of choice for psychotic-like symptoms.
- Antipsychotics may also improve depressed mood, impulsivity, and anger-hostility.
- Antipsychotics are most effective when cognitive-perceptual symptoms are primary.
- If response is suboptimal in 4 to 6 weeks, increase dose to the range used for axis I disorders.
- Clozapine may be useful for patients with severe, refractory psychotic-like symptoms.

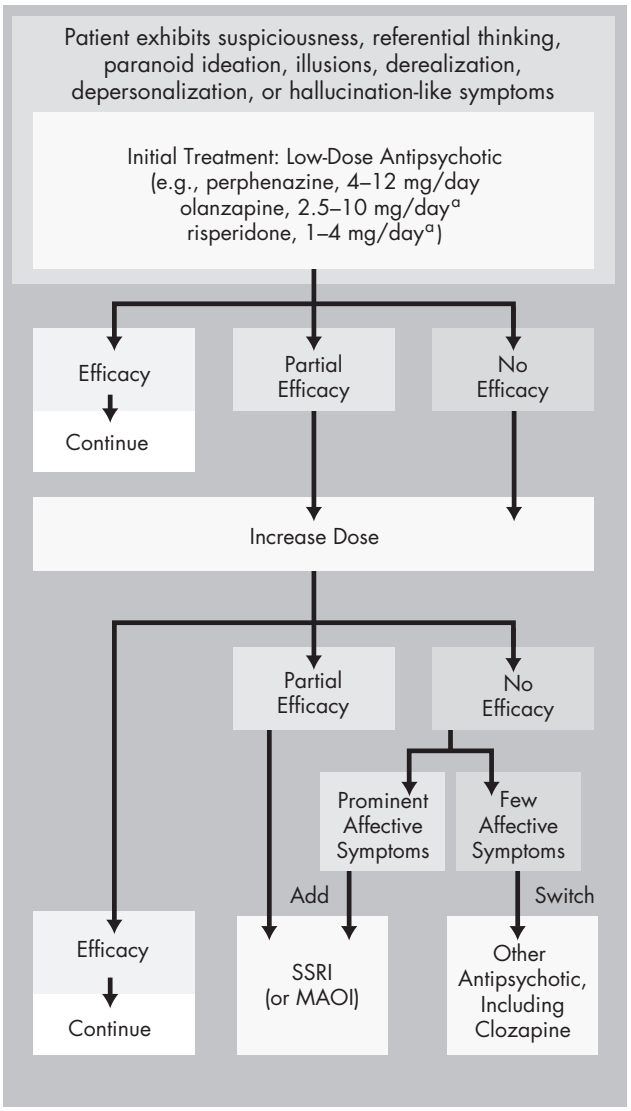
FIGURE 2. Psychopharmacological Treatment of Impulsive-Behavioral Dyscontrol Symptoms in Patients With Borderline Personality Disorder



[a]Especially if serious threat to patient is present.

[b]SSRI treatment must be discontinued and followed with an adequate washout period before initiating treatment with an MAOI.

FIGURE 3. Psychopharmacological Treatment of Cognitive-Perceptual Symptoms in Patients With Borderline Personality Disorder



[a]The generally favorable side effect profiles of the second-generation antipsychotics compared with those of first-generation antipsychotics underscore the need for careful empirical trials of these newer medications in the treatment of patients with borderline personality disorder.

E. Special Features Influencing Treatment

Address comorbidity with axis I and other axis II disorders.
- For guidance, refer to other APA practice guidelines.
- Comorbid depression, often with atypical features, is particularly common.

Treat problematic substance use.
- Substance abuse often leads to less favorable outcomes, including increased risk of suicide or accidents.
- Substance abuse may lower threshold for other self-destructive behavior.
- Vigorous treatment is essential.

Address violent behavior and antisocial traits.
- For mild antisocial behavior, provide psychotherapy, psychoeducation, or both to help the patient understand the advantages of socially appropriate alternatives.
- For more severe antisocial behavior, consider residential treatment, mood stabilizers, or SSRIs.
- If antisocial traits predominate or threat of violence is imminent, psychotherapy may prove ineffective. If violence is threatened or imminent, hospitalization may be indicated and potential victims may need to be warned.

Address chronic self-destructive behavior.
- Limit setting is often necessary—consider a hierarchy of priorities (see Figure 1 of APA's *Practice Guideline for the Treatment of Patients With Borderline Personality Disorder*).
- Target behaviors that are destructive to the patient, the family, the therapist, or the therapy.
- If the patient is out of control, consider a more intensive treatment setting.

Address trauma and posttraumatic stress disorder (PTSD).

- It is important to recognize any existing trauma history.
- Recognize trauma transference issues (e.g., expectation that the therapist will be malevolent).
- Working through trauma is best done at a later phase of treatment; it involves exposure to memories, managing affect, and cognitive restructuring.
- Recognize that patients may be at increased risk of further trauma and revictimization.
- Group support and therapy can be helpful.
- Be aware of and treat PTSD-like symptoms if present.
- Clarify the patient's lack of responsibility for past trauma if appropriate and the importance of taking responsibility for present life circumstances.

Address dissociative features.

- Explore dissociative symptoms and their triggers.
- Teach the patient how to access and control dissociation.
- Facilitate integration of dissociative identities.
- Provide positive reinforcement for integrated functioning.

Address psychosocial stressors.

- Stressors, particularly of an interpersonal nature, may exacerbate symptoms.
- Limits of the therapeutic relationship may stimulate anxiety-driven reactions.

Consider gender, age, and cultural factors.

- Borderline personality disorder may be missed in males, who may be misdiagnosed as antisocial or narcissistic.
- Treatment of pregnant and nursing women raises special considerations regarding the use of psychotropic medications.
- Cultural factors may hamper accurate assessment. Cultural bias in assessment of sexual behavior, emotional expression, and impulsivity should be avoided.
- Diagnoses in adolescents should be made with care because personality is still developing.

F. Risk Management Issues

1. General Considerations

- Collaborate and communicate with other treating clinicians.
- Provide careful and adequate documentation, including assessment of risk, communication with other clinicians, the decision-making process, and the rationale for the treatment approach.
- Attend to problems in the transference and countertransference and be alert for splitting.
- Consider consultation with a colleague for unusually high-risk patients, when a patient is not improving, or when the best treatment approach is unclear.
- Follow standard guidelines for terminating treatment.
- Consider providing psychoeducation about the disorder (e.g., risks of the disorder and uncertainties of treatment outcome).
- Assess the risk of suicide; the potential for angry, impulsive, or violent behavior; and the potential for boundary violations.

2. Suicide

- Monitor the patient carefully for suicide risk and document these assessments.
- Actively treat comorbid axis I disorders, with particular attention to those that may contribute to or increase the risk of suicide.
- Take suicide threats seriously and address them with the patient.
- Consider consultation and/or hospitalization.
- In the absence of acute risk, address chronic suicidality in the therapy.
- Consider involving the family when the patient is either chronically or acutely suicidal.
- Do not allow a "suicide contract" to substitute for a careful and thorough clinical evaluation of the patient's suicidality.

3. Anger, Impulsivity, and Violence

- Monitor the patient carefully for impulsive or violent behavior.
- Address abandonment/rejection issues, anger, and impulsivity in the treatment, because they may be triggers of violence.
- Arrange for adequate coverage when away; carefully communicate plans for coverage to the patient and document the coverage.
- If threats toward others or threatening behavior is present, action may be necessary to protect self or others.

4. Potential Boundary Violations

- Monitor carefully and explore countertransference feelings toward the patient.
- Be alert to deviations from the usual way of practicing (e.g., appointments at unusual hours), which may be signs of countertransference problems.
- Avoid boundary violations such as the development of a personal friendship outside the professional situation or a sexual relationship with the patient.
- Get a consultation if there are striking deviations from the usual manner of practice.