38 TREATING BORDERLINE PERSONALITY DISORDER

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Borderline personality disorder (BPD) is a highly prevalent, chronic, and debilitating disorder characterized by emotional lability, impulsivity, interpersonal dysfunction, angry outbursts, and suicidality. Prevalence rates in the general population range from 0.4% to 5.9%, with a rate of 2%–3% being most typical. Prevalence in outpatient samples range from 10% to 20% and are about 20% to 25% in inpatient samples.

BPD is frequently comorbid with other disorders such as depression, bipolar disorder, anxiety disorders, posttraumatic stress disorder, eating disorders, substance abuse, and other personality disorders. This pattern of comorbidity is often referred to as *complex comorbidity* because of the number of comorbid diagnoses and the pattern that includes both internalizing and externalizing disorders. In addition to representing common comorbidities, differential diagnosis from these disorders is important. One especially complicated differential diagnosis is bipolar disorder, particularly bipolar II.

BPD has historically been thought to be difficult to treat, with patients frequently not adhering to treatment recommendations, using services chaotically, and repeatedly dropping out of treatment. Many clinicians are intimidated by the prospect of treating BPD patients and are pessimistic about the outcome of treatment. Psychotherapists treating patients with BPD have displayed high levels of burnout and have been known to be prone to enactments and even engagement in iatrogenic behaviors. However, controlled trials strongly suggest that, contrary to popular belief, BPD is a treatable disorder.

Below are 12 evidence-based principles and recommendations from the burgeoning research literature on the treatment of BPD over the last 20 plus years:

1. Evidence suggests that clinicians may not recognize and do not diagnose personality disorders in ordinary clinical practice. Fully 74% of patients in a study for BPD had previously been misdiagnosed despite an average of 10 years since their first psychiatric encounters (Meyerson, 2009). The most common false-positive diagnoses were bipolar disorder, depression, and anxiety disorders. Left to their own judgments, clinicians diagnosed BPD in 0.4% of almost 500 patients seen, compared to 14.4% by structured interview (Zimmerman & Mattia, 1999). Providing clinicians with the findings from the structured interviews significantly increased the likelihood of the BPD diagnosis from 0.4% to 9.5%. These findings suggest that training in, and use of, structured assessments (e.g., structured interviews) are important for identifying BPD, which in turn has strong clinical utility for treatment planning. Clinicians who do use structured assessments are likely to miss many cases of BPD, which can result in incomplete treatment.

2. Given that BPD is commonly comorbid with several disorders, whenever a clinician determines that a patient meets criteria for one of these disorders (major depression, bipolar disorder, an anxiety disorder, posttraumatic stress disorder, or a substance use disorder), it is incumbent upon them to assess whether there is a comorbid BPD diagnosis because it will likely affect the course and treatment of the disorder. Likewise, complex comorbidity and/or a history of being diagnosed with various psychological disorders suggest clinicians should formally assess for BPD.

3. When comorbid, BPD negatively affects the course of these disorders and the efficacy of otherwise efficacious treatments of these disorders. For example, bipolar patients with comorbid BPD are less likely to be employed, use more medications, and have increased rates of alcohol and substance use disorders, show poorer treatment response, and have significantly worse interepisode functioning. Interestingly, a comorbid bipolar disorder does not affect the course or outcome for BPD patients (Gunderson et al., 2006). Additionally, a number of studies have now found that improvements in BPD were often followed by improvements in major depressive disorder but that improvements in major depressive disorder were not followed by improvements in BPD (Gunderson et al., 2004; Klein & Schwartz, 2002; Links et al., 1995).

4. Although common comorbidities (e.g., major depression) may require simultaneous treatment with BPD, it is important not to assume that treatment of these conditions will result in the remission of BPD and privilege those treatments to the neglect of treating BPD. The evidence strongly suggests the contrary.

5. Psychotherapists should typically share the results of their diagnostic assessment with the BPD patients. Studies have found that mental health professionals report difficulty disclosing BPD diagnoses. This can often be anxiety provoking for the therapists who might fear the patient's response. However, many patients with BPD suspect that they may have BPD and/or may learn their diagnosis from secondary sources (e.g., other treaters, bills, insurance documents, medical records). It is usually best to have an open and sensitive discussion with the patient about the nature of his or her difficulties and how best to proceed in treatment. Doing so is typically part of setting the treatment frame and agreeing on therapy goals.

6. There are now several treatments—deriving from both the cognitive-behavioral and psychodynamic traditions—that have shown efficacy in randomized controlled trials and are now available to clinicians and their patients. These treatments include dialectical behavior therapy (DBT; Linehan et al., 2006), mentalization based therapy (MBT; Bateman & Fonagy, 2010), schema focused psychotherapy (SFPT; Gisen-Bloo et al., 2006), transference focused psychotherapy (TFP; Clarkin et al., 2007; Levy et al., 2006), dynamic deconstructive psychotherapy (DDP; Gregory & Remen 2008), and a number of versions of supportive-dynamic psychotherapies. There is also a number of short-term psychoeducational, cognitive-behavioral-therapy-base d or skill-based groups designed to be used as adjunctively that show promise, particularly STEPPS (Blum et al., 2008). Thus, practitioners and patients have a range of options across a number of orientations available to them. Although DBT has been tested in more randomized controlled trials than the other treatments, findings from both direct comparisons and meta-analytic studies are clear that there are a number of equally good treatments available to patients with BPD and that there is no credible evidence that any one treatment is significantly better than any other

7. It is important that clinicians who treat individuals with BPD have training in one or more of the empirically supported treatments and employ evidence-based principles deriving from these treatments. These empirically supported treatments all represent modifications of standard psychodynamic (PDT) or cognitive-behavioral therapy (CBT) treatments and tend to integrate aspects of different traditions. Additionally, the evidence suggests that standard unmodified PDT and CBT are not effective for individuals with BPD.

8. Despite positive findings from randomized controlled trials, only about half the patients in treatment respond regardless of treatment. Additionally, although many patients have shown symptomatic improvement and even diagnostic remission, they still experienced significant social and functional impairments (e.g., Skodol et al., 2005). Thus, a significant portion of individuals receiving an efficacious treatment are not improving, and these individuals might be better served in different treatments. Additionally, given the heterogeneity of BPD, having different treatment options is important because it is unlikely that any one treatment will be useful for all patients.

9. Medications appear useful as adjunctive in the treatment of BPD but are generally not thought to be sufficient by themselves. The frequent targets are three symptom domains of mood, thought process, and impulsivity. However, polypharmacotherpay has been associated with a number of untoward effects, including paradoxical side effects, adverse events, iatrogenic symptoms, and negative health outcomes such as obesity and diabetes (being on three or more psychotropic medications is a greater risk factor for obesity than a family history of obesity or a sedentary lifestyle). Additionally, prescribed medications are often used in drug overdoses. There is some evidence for the superiority of monopharmacotherpay with BPD patients and for selecting medications based on tolerability and safety rather than symptom picture (see Zanarini, 2004). Additionally, some randomized controlled trials have convincingly shown that you can decrease medication use and obtain efficacy for psychotherapy (Bateman & Fonagy, 1999, 2008; Linehan et al., 1991).

10. Considering the commonalities across the empirically supported treatments allows us to derive a number of important strategies, tactics, and techniques for treating BPD:

- Provide a structured, coherent, and explicit treatment that makes sense to both the clinician and the patient and identifies a hierarchy for priorities in treatment. Such a structure provides guidance to the therapist during times of intense affect and provides the patient with a sense of containment.
- Consider being in supervision or intervision to protect against burnout, implicit collusions with the patient, therapist acting out, and engagement in iatrogenic behaviors.
- Pay particular attention to and be explicit about the treatment frame (or contract), including the rationale for the treatment, patient and therapist responsibilities, and explicit instructions for handling emergencies. The need for an explicit frame is common to all treatments of BPD.
- Develop the treatment frame and priorities collaboratively and not experienced as an imposition by the patient. Therapists should be attentive for signs of acquiescence by the patient as it does not represent a true agreement. Likewise, it is important for therapists not to acquiesce as they contain expertise relevant to helping the patient. Developing a truly collaborative frame may take a number of sessions and require occasional revisiting.
- Emphasize repeatedly the treatment frame or contract. Many aspects of treatment may not be explicit or as well articulated in the patient's mind as is often the case with healthier patients. Patients should be clear about what is expected of them, realistic goals, and potential treatment interfering behaviors or events. Setting a solid frame is part of providing a safe haven for the patient to explore his or her difficulties and for the therapist to work within. The absence of a treatment frame potentially licenses the patient to engage in treatment-interfering behaviors and/or acting-out behaviors.
- Explore difficulties that have arisen in past treatments because they can provide important indicators of the kinds of difficulties that might arise in your treatment with the patient (e.g., lateness, missed sessions, feeling that the therapist is trying to control the patient).
- Assess the nature of interpersonal relating between the patient with past therapists and significant others (particularly around the patient's most problematic behaviors—for example, self-injury) as these dynamics can

guide the current treatment. For example, if the patient tends to feel controlled by others and often responds to this feeling by not talking in session or withholding important information from the therapist or others in his or her life, which in turn leads to a crisis, it will be important to discuss the likelihood of this happening in the new therapy and come to some collaborative agreement about how to structure the therapy to address this issue.

- Avoid rigidity in setting the contract (e.g., prohibiting behaviors such as self-injury). Rather, it is important that the patient can agree with the therapist that reducing certain behaviors would be a treatment goal and setting up conditions that facilitate the patient bringing up such feelings and minimizing the likelihood of it occurring. Setting up a rigid frame or coming to a premature agreement about the frame is associated with early dropout.
- Make special efforts to attend to and manage the therapeutic relationship, which will prove more variable with patients diagnosed with BPD and attend to that variability to provide them with clues to the patient's mental states. Positive and negative alliances should be discussed with the patient.
- Consider the addition of a group component to individual sessions. The added value of a group component is unclear; however, research strongly suggests that all aspects of treatment, adjunctive or otherwise, including medications, need to be well coordinated and require collaboration among the various professionals. In this regard, treatments provided within an agency or organization appears to be more effective than treatments across organizations—most likely a result of better communication between treaters.

11. Because BPD is a chronic disorder that has developed over many years, it will most likely require a longer term treatment that meets at least weekly. All the efficacious treatments for BPD are a multiyear process (although most have only examined efficacy after 1 year of treatment). These treatments tend to meet for 2 to 5 hours a week.
12. BPD is a heterogeneous disorder. Only about 50% of patients respond to any of these treatments, and treatment responses, while clinically significant, are nonetheless incomplete. Hence, communities can offer several of the evidence- based treatments to patients or a given therapist can obtain expertise in different therapies.

References and Readings

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