

Personality Disorders- Borderline

DSM-IV-TR Diagnostic Code: 301.83 Borderline Personality Disorder

Diagnostic Guidelines:

1. Establish Diagnostic accuracy as defined in DSM-IV-TR/ICD-9 and confirm through continued assessment of diagnosis over time, external corroboration of diagnosis when possible through review of past treatment history, legal history, etc., and rule out of other diagnoses as necessary
2. Identify differential diagnoses and co-morbid problems: Rule out mood disorders, post-traumatic stress disorder, substance related disorders, and other Cluster B personality disorders. Use psychological testing to assist with rule outs when necessary.
3. Review previous treatment episodes to determine efficacy of treatment interventions and therapeutic gains.
4. Assess risk factors common to this disorder such as violent behavior, suicidal ideation and/or gestures, chronic self-injury, or episodes of dissociation, and make a realistic plan to address safety.

Treatment Guidelines

1. Treatment of choice for this disorder is usually outpatient psychotherapy, with the possible addition of medications targeted at specific symptoms. Although often not responsive to traditional talk therapy, aspects of BPD have been shown to improve with specific, targeted treatment strategies. Treatment for Borderline Personality Disorder is likely to be somewhat lengthy in duration, typically lasting at least a year or more for most.
2. The general goals of treatment for BPD clients include validating one's suffering, accepting the magnitude of the therapeutic task, learning to take responsibility for one's actions, increasing the amount of reflection and decision making before acting, decreasing impulsivity, decreasing black-and-white thinking, identifying and moderating inappropriate behaviors and feelings, and fostering more effective interpersonal relationships.
3. It may be important to educate the client's family or significant others about the nature of BPD and effective strategies that will allow the other person to support and interact with the client.
4. The most successful and effective psychotherapeutic approach to date has been Marsha Linehan's Dialectical Behavior Therapy (DBT). DBT seeks to teach the client how to better take control of their lives, their emotions, and themselves

- through self-knowledge, emotion regulation, and cognitive restructuring. It is a comprehensive approach most often conducted in a group setting. Because the skills learned are new and complex, it may not be appropriate for those who may have difficulty learning new concepts, or those not committed to change. An important aspect of Dialectical Behavior Therapy is the collaboration between the client's clinician and the group facilitators. It is important that the client's use of the skills learned in group is reinforced by the clinician in individual sessions.
5. Other therapies have also shown some positive outcomes for this disorder, including Comprehensive Validation Therapy, interpersonal therapy, cognitive therapy, cognitive analytical therapy, and STEPPS (systems training for emotional predictability and problem solving).
 6. People with this disorder often see others in black and white terms. Depending upon the circumstances, a clinician can be seen as either very helpful and caring, or antagonistic and not caring toward the client. Clinicians should be aware of this "all-or-nothing" lability often found in individuals with this disorder and be careful not to validate it.
 7. The therapist should work with the client to clearly agree up front on both the goals of treatment and the treatment framework. Providing a structured therapeutic setting is important. Because people with this disorder often test the limits of the clinician in treatment, well-defined boundaries of your relationship with the client need to be carefully explained at the onset of therapy. Clinicians need to be especially aware of their own feelings toward the client (counter-transference) when the client may display behavior which is deemed inappropriate. Supervision/consultation and working with a group may help the clinician keep the client's behavior in perspective.
 8. People with this disorder often present in crisis at their local community mental health center, to their clinician, or at the hospital emergency room. While an emergency room is an immediate source of crisis intervention for the client, it is a costly treatment and regular visits to the E.R. should be discouraged. Instead, clients should be encouraged to find additional social support within their community including self-help support groups, contact a crisis hotline, or contact their clinician or treating clinician directly.
 9. Clinical staff and ER personnel should coordinate care to reduce the chances of splitting, over medicating, or providing unnecessary treatment. Every attempt should be made to contact the client's attending clinician as soon as possible. Management of the immediate problem is usually the key to effective treatment of this disorder when it presents in a hospital emergency room, with discharge to the client's usual care provider.
 10. Inpatient treatment of this disorder is generally not appropriate, except to stabilize serious and imminent risk of self harm.
 11. A highly structured partial hospitalization or a day treatment program may be

useful as a substitute for inpatient care to maintain safety during times of increased stress or episodic decompensation.

12. Medications for persons with BPD are most often targeted at affective instability, impulsivity, psychotic-like cognitive-perceptual symptoms, and self-destructive behavior. SSRI medications and low-dose neuroleptics are the most likely choices. Encouraging the individual with borderline personality disorder to gain additional social support is an important aspect of treatment. Clients should be encouraged to try out new coping skills and emotion regulation with people in support groups. They can be an important part of expanding the individual's skills and developing new, healthier social relationships.

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