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Review Article

Borderline Personality Disorder: Treatments and Critique

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Abstract

Earlier recognised as a condition where the patient is lying at the border of 2 other disorders, borderline personality disorder affects a considerable amount of the population. Interestingly, a patient can receive the BPD diagnosis in 150 different ways based on various combinations of the criteria needed for the diagnosis of the disorder [28], which makes the clarity needed around diagnosis even more indispensable. This stresses the importance of using well researched and evaluated methods of management which will be discussed in the essay, saving on the lethal consequences on their lives, impact on their support networks and costs of health services. After defining the underlying features of this disorder, the present essay attempts to critique the various forms of treatment which are used to treat the disorder.

Keywords: Borderline Personality; Treatment Plan for Borderline Personality Disorder

Introduction

Deemed a complex disorder, it is crucial that it is dealt with a detailed and tailored understanding of treatment options. With the mortality rate being 8 - 10% (at a rate 50 times higher than the general population) [23], evaluation is the need of the hour. It is likely that a person in primary care with repeated instances of self-harm, persistent risk behaviour and emotional instability would be referred for assessment for borderline personality disorder [17]. The fifth edition of the DSM [1] lists nine symptoms (Criterion A), the presence of 5 or more of which leads to a diagnosis. The International Classification of Diseases, describes a condition it refers to as 'Emotionally Unstable Personality Disorder' (F60.3), which it further divides into an impulsive type (F60.30) and a borderline type (F60.31) [33].

Major symptoms

- Dysfunctional interpersonal patterns: instability in interpersonal relationships fuelled by fear of abandonment and rejection, which is often characterised by alternating between extremes of idealisation and devaluation [1].
- Suicidal ideation and self -harm along with high rates of hospitalisation [7].
- High mental and physical comorbid problems, along with other personality, mood, post-traumatic stress, anxiety, eating disorders, depression, alcohol and drug misuse (with some like substance use being more common in men and eating disorders in women, rendering them frequent users of psychiatric and acute hospital emergency services)[26].
- Identity disturbance and persistent instability of self -image, mood, aims and internal preferences.
- Impulsivity**,** which as the DSM-5 points out is displayed in at least 2 potentially self – damaging areas, for example; spending, sex, substance abuse, reckless driving, binge eating [1].
- Feelings of emptiness
- Difficulty controlling anger and dissociative symptoms or stress-related paranoid ideation [1].
- Psychotic symptoms including brief delusions and hallucinations may also be present in some cases.

- Affective instability, example intense episodic dysphoria, irritability or anxiety of mood due to a marked reactivity of mood [1].
- They may experience repeated crisis involving poor functioning as a result of social, psychological and occupational impairment, which may be due to a biologically – predicated consistent perception that their emotional needs are not validated [20].

More commonly diagnosed in women than men [3], the primary symptoms are shown in early adulthood. Common risk factors and psychopathology among adults and young people include:

- sexual, physical abuse,
- maternal hostility,
- verbal abuse/neglect [34].

Diagnosis

The Diagnostic Interview for Borderline Personality Disorder [12] couldn't cater to the heterogeneity of the sample which led to the development of structured interviews designed to assess all of the DSM criteria, which are used currently(e.g., the Structured Clinical Interview for DSM-IV Personality Disorders) [11]. The current approach to diagnosis includes asking questions about each criterion directly, which is a more reliable alternative to the structured interview. While considering the diagnosis, it is essential to consider the level of self-awareness of the patient and to what extent that can be relied upon, given the noted instability, distortions about self and others and fluctuations which form the core of this disorder. Pairing the systematic clinical interview with psychometrically valid instruments for rating the data gathered in the interview, for example the SWAP-II Q-sort [27], gives patients an opportunity to provide detailed narratives, from which the clinician may make judgements by reflecting the same through the ranking of items. It is suggested that data be gathered from multiple sources including self-report questionnaires, clinical observations and judgements, informant ratings, laboratory tasks, among others. One must not forget the importance of offering post-assessment support, particularly if sensitive issues like childhood trauma/abuse were discussed.

Treatment

With a spectrum of varying discomforts, people with borderline personality disorder (BPD) can be challenging to engage with and even after treatment, patients may be present in health services [3]. They are often treated by a team rather than just an individual to meet the intense demands. As important as the type of treatment route undertaken by the mental health professional, it is imperative that the therapeutic relationship is paid particular attention to, by instilling the belief that recovery is attainable in an atmosphere of hope and optimism. It is a trusting, open, engaging and non-judgemental patient-therapist relation which provides a consistent and reliable cushion to the sometimes misunderstood BPD patient who due to the self-harm and stigma around BPD, may have experienced rejection, abuse or trauma in the past [22]. The team of professionals working with the patient may choose from among a list of treatments ranging from psychotherapy, crisis management, pharmacotherapy, cognitive behavioural therapy, schema therapy, psychodynamic, transference-focused or mentalisation-based treatment among others. The main point to consider important in treatment is that their focus should be on stabilisation of behaviour, reduction of emotional dysregulation, understanding past and present relationships, reorganisation of internal and external behavioural processes.

The choice, willingness and motivation of the patient together with the degree of impairment will finally inform the treatment protocol and design. The same would be incomplete without providing tailored training in programs of social care, forensic, primary care providers and addressing problems around stigma and discrimination, providing bespoke treatment for the individual.

Psychotherapy is considered the treatment of choice in borderline personality, a disorder associated with mortality and low quality of life [24]. Even though research tilts towards psychological therapy programs like dialectical behavioural and mentalisation-based therapy, it must not be forgotten that trials are relatively small, research is at an early stage of development, and most trials have not included large numbers of men.

Despite the changes that psychosocial interventions may introduce in patients suffering from the disorder, the data collected from cohort studies or case studies cannot provide a vibrant picture of their efficacy which could be better delivered by trials of these interventions in experimental and consequentially longitudinal studies. A mixed-methods cohort study, including both qualitative and quantitative material including data from both service users and providers at different levels and transitions through the treatment

pathway from referral guide, to primary and secondary care services and inpatient treatment, is suggested [22].

Any discussion would be incomplete without considering the need for acute crisis management, which has not been mentioned enough in literature when talking about treatment techniques. Due to the occurrence of adverse events which may sometimes take place (death, self-harm, violence, hospital admission) various techniques including home-based, intensive case management, initial crisis intervention, joint crisis plan, have been established [10]. The absence of research renders it challenging to evaluate the efficacy of crisis intervention, but the importance for a cohort of patients who are difficult to recruit, require extra time to build trust, renders it even more critical to hold studies like these [5].

Another form of treatment not usually mentioned is pharmacotherapy [22]. Even though antipsychotic drugs are not recommended for medium or long term treatment, they may be considered for the overall treatment of comorbid conditions [22]. A review of 28 trials involving 1742 participants revealed that using second-generation antipsychotics, mood stabilisers, dietary supplements may be beneficial. Nonetheless, anti-depressants are not widely supported along with adverse effects reported for some drugs like olanzapine [30]. Overall, medication has not been found to be effective in reducing the overall severity of BPS [18].

Often mentioned in research, cognitive behavioural therapy (CBT)targets thoughts, feelings, actions, irrational beliefs and unhelpful thoughts, while dialectical behavioural therapy (DBT) focuses on changing unhelpful behaviours, and fosters acceptance of oneself. The dictionary meaning of 'dialectical' translates to "the art of investigating or discussing the truth of opinions". The therapist attempts to discuss, understand and synthesise beyond the black and white world of the patient. As Linehan (2015) [20] pointed out, by creating an atmosphere of validation, DBT caters to patients with emotional dysregulation, eating disorders, substance abuse, depression, among others, by working on their skills. Based on a cognitive-behavioural approach and originally developed to treat chronically suicidal individuals, it is especially recommended for women for whom reducing self-harm is a priority [22]. A comparison of 7 studies involving 262 people, found that DBT leads to a reduction in suicidal ideation and general psychiatric severity after 6/12 months [3]. The decline in anxiety and depressive symptoms maybe because of the outlook of DBT which includes prioritising hierarchy of target behaviours. By engaging the patients in cognitive modification and working on emotional cues, empathy, reflection, acceptance, it may also reduce the rate at which people leave the study. Randomised controlled trials have shown that DBT is more effective than community-based approaches [32], and with patients showing comorbidity with substance abuse [19], leading to:

- Reductions in BPD specific and transdiagnostic psychiatric symptoms, dropout rates, parasuicidal behaviours, maladaptive behaviours, suicide attempts; frequencies of hospitalisation and
- Improvements in quality of life and social adjustment [14].

It is argued that because it is easily deliverable by people across age groups, disciplines, educational backgrounds, in inpatient/outpatient settings, it may be easy to administer. It also addresses emotional regulation by involving the psychoeducation of adaptive and new coping skills training sessions. Understanding the broad spectrum of distress and behavioural ranges, it works by targeting major areas of interpersonal effectiveness and understands the root of the impulsive and self – injurious behaviour. It works on areas like distress tolerance through mindfulness, weekly psychotherapy, DBT skills sessions etc. By validating their actions, taking an understanding approach, and being available round the clock, it is postulated that a cushion where trusting bonds can be embroidered is implanted.

Another type of therapy based on the principles of CBT is schema therapy, which helps patients to change their self -defeating schemas using cognitive/behavioural and emotion-focused techniques. It is posited that as it works with early maladaptive schemas and coping styles, core emotional needs, it would aid in identifying unhealthy life patterns by understanding past traumatic experiences while also focusing on the present maladaptive styles.

Behaviour therapy, on the other hand, focuses mainly on altering specific behavioural components, which is used by DBT too using procedures like exposure, cognitive modification, contingency management and problem-solving. It is hypothesised that it may affect only some symptoms and may not touch upon the root cause of unhelpful thoughts and beliefs as much, which is taken up by psychodynamic therapy in its approach.

Focusing on unconscious conflicts repressed by the individual and the therapeutic relationship, short-term psychodynamic therapies do not show much effectiveness as a treatment for children and young people diagnosed with BPD. But, some research has shown that when compared to general psychiatric care, after receiving psychodynamic therapy, BPD patients were less likely to be admitted into inpatient care, needed less psychotropic medication, and showed better social improvement [3].

It is believed that as this approach presumably inquires into the patients adaptive functions, interpersonal relationships(through object relations; using the relationship with the therapist to address the same), it offers opportunities to confront feelings like aggression. This would provide them with a more balanced view of self and others and would help them internalise soothing functions, which may not be offered in other forms of therapy.

Doing away with traditional psychodynamic hallmarks like using the couch, and the traditional therapist-client relationship, transference-focused therapy (TFP)is based on the concept of transference. It works on the process of clarification, confrontation and interpretation which takes place within the context of the patient-therapist relationship [6]. By focusing on the transference of the 'victim-victimiser' dynamic, for example, in the patient-therapist relationship, it makes the patient aware of the poorly integrated representations in self/others. The author argues that it can teach patients to regulate emotions and enhance awareness of dynamics in interpersonal relationships by working through a hierarchy of goals ranging from suicidal and self-destructive goals to dominant relationship patterns. A randomised controlled trial comparing TFP with psychodynamic and DBT found that only TFP led to a change in the structure of representations of self and others.

However, a major area which is not at the core of other therapeutic approaches is attachment, which forms the basis of mentalization-based treatment. The trajectory from naming emotions, understanding their role in past and future relationships, working on appropriate expression and understanding reactions of others may assist them in being in the 'here and now' which is what not all approaches would focus on, but which is indispensable. This may also suggest how mindfulness may be used, which will be discussed later in the essay.

Other forms of treatment, example, protocolized psychological treatment may be advised for less severe patients of BPD, in community health terms, and may not work very well with severe patients of BPD [2]. Another one, general psychiatric management (a medicalised therapy) includes regular psychiatric reviews, inpatient admission focuses on situational stressors [4], but may not work with patients with severe BPD even though it may be easier to administer.

Based on a systematic review of 20 studies however, it has been posited that specialised psychotherapies generally lead to an improvement in overall BD severity [along with a moderate effect on reducing self-injury [24], when compared to treatment as usual or community treatment. This may suggest that they provide a certain edge to otherwise generalised therapeutic outcomes by connecting etiological and maintenance factors to therapeutic techniques.

As clearly indicated in the essay, talking therapies have positive effects on these patients [3]. Lack of resources, research support and practitioners have not given the opportunity of any limelight to an alternative form of therapy, i.e. Expressive arts therapy. It is posited that not only does this alternative form cover all the positive aspects of other therapeutic approaches but it may also lead to transcendental and fundamental changes. It involves the use of drama, music, movement, painting, literature etc. for psychotherapeutic approaches which lead to the enhancement of physical, emotional and cognitive functions of individuals [25]. Synthesizing the principles of mindfulness, interpersonal effectiveness, psycho-education, distress tolerance and regulation of emotion (dialectical behaviour therapy), stressing on the patient-therapist relationship(psychodynamic, transference-focused therapy), using emotion-focused techniques(schema therapy), promoting introspection (mentalisation therapy), it combines the strengths of the various methods mentioned before in the essay. With some of its aims to enhance growth, self -understanding as well as awareness and control of emotion it can work to aid the BPD patient in various stages. These may range from insight, overcoming overwhelming emotions and trauma, solving conflicts, experiencing oneness with one's sense of being, managing emotional and physical disturbances constructively, leading to a metamorphosis of the self, which the other techniques may not necessarily offer completely. The small amount of research done has also pointed out that the use of art therapy with patients of borderline personality disorder,

increases distress tolerance and lowers service use [29]. Having transcendental properties, it offers revolutionary changes in identity, interpersonal connections and an opportunity to channelise intense emotions [21]. Lastly, it provides them, in an accepting and understanding environment, the incomparable power of expression [16].

The only thing stable in an individual suffering from borderline is their instability, ranging from immense confidence to sudden despair; the individual may fluctuate between feeling angry, anxious, depressed, abandoned, dependent, rejected. Their emotions tend to spiral out of control, and given this, they not only require support from their therapist but also acceptance from their family and general social circle.

Conclusion

The essay has identified and evaluated different intervention strategies, and henceforth group therapy is suggested, leading to more significant improvement in social functioning, along with a consideration of alternative therapeutic approaches which would combine the strength of other methods. To cover even most of the range of treatments for BPD is beyond the scope of this essay; however, the importance of establishing a clear framework which lays down expectations, boundaries, length, duration, focusing on emotional dysregulation and the therapist-client relationship is what should mostly guide treatment for BPD.

The small number of participants included in almost all of the studies using meta-analysis alerts to the need to carry out more randomised control trial based studies in this area. With not many negative studies being reported, a clear picture of what isn't truly working may not be reflected in a just manner. Looking at comparisons between psychological therapy programs with outpatient follow up community mental health services, would help in a richer assessment of their effectiveness and cost. With reconsiderations of personality disorders in the 11th version of the ICD (presented in the World Health Assembly in May 2019), there is scope to see the different ways that separately occurring traits in BPD patients are treated differently rather than focusing the treatment only on the global traits of the disorder.

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