



Complete Summary

GUIDELINE TITLE

Practice guideline for the treatment of patients with borderline personality disorder.

BIBLIOGRAPHIC SOURCE(S)

Practice guideline for the treatment of patients with borderline personality disorder. American Psychiatric Association. Am J Psychiatry 2001 Oct; 158(10 Suppl): 1-52. [198 references]

COMPLETE SUMMARY CONTENT

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SCOPE

DISEASE/CONDITION(S)

Borderline personality disorder

GUIDELINE CATEGORY

Diagnosis
Management
Risk Assessment
Treatment

CLINICAL SPECIALTY

Psychiatry

INTENDED USERS

Physicians

GUIDELINE OBJECTIVE(S)

- To provide a practical guide to the management of patients with borderline personality disorder
- To represent a synthesis of current scientific knowledge and rational clinical practice

TARGET POPULATION

Adults with borderline personality disorder

INTERVENTIONS AND PRACTICES CONSIDERED

Initial Assessment and Evaluation

1. Initial assessment including consideration of treatment setting (e.g., inpatient or outpatient) and safety issues.
2. Comprehensive evaluation and establishment of treatment framework with patient collaboration in treatment goals.

Psychotherapy

1. Therapeutic approaches including psychoanalytic/psychodynamic therapy, cognitive behavior therapy, group therapy, couples therapy, family therapy.

Pharmacotherapy and other Somatic Treatment

1. Selective serotonin reuptake inhibitors (SSRIs), such as fluoxetine, sertraline; and related antidepressants, such as venlafaxine.
2. Tricyclic and heterocyclic antidepressants, such as desipramine, imipramine, amitriptyline, mianserin.
3. Monoamine oxidase inhibitors (MAOIs), such as phenelzine, tranylcypromine.
4. Mood stabilizers, such as lithium carbonate, carbamazepine, valproate.
5. Benzodiazepines, such as alprazolam, clonazepam.
6. Typical neuroleptics, such as haloperidol, perphenazine, thiothixene, thioridazine, flupentixol, loxapine, chlorpromazine, trifluoperazine.
7. Atypical neuroleptics, such as clozapine, olanzapine, risperidone.
8. Opiate antagonists, such as naloxone (considered but not recommended).
9. Electroconvulsive therapy (ECT) (considered but not recommended).

Additional Management Strategies

1. Psychoeducation for patients and families.
2. Treatment and consideration of comorbid psychiatric disorders and substance abuse disorders.
3. Risk management issues including adequate documentation; consultation with colleagues; termination of treatment; suicidal, angry, impulsive or violent behaviors; and boundary violations.

MAJOR OUTCOMES CONSIDERED

- Degree of control of specific symptoms, such as aggression, anger, impulsivity, self-injurious or suicidal behavior, depression, anxiety, irritability, poor global functioning
- Scores on psychiatric rating scales and patients' self-ratings
- Number of hospital admissions and psychiatric hospital days of treatment
- Adverse effects of treatment

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

A computerized search of the relevant literature from MEDLINE and PsycINFO was conducted.

The first literature search was conducted by searching MEDLINE for the period from 1966 to December 1998 and used the key words "borderline personality disorder," "therapy," "drug therapy," "psychotherapy," "pharmacotherapy," "psychopharmacology," "group psychotherapy," "hysteroid dysphoria," "parasuicidal," "emotionally unstable," and "treatment." A total of 1,562 citations were found.

The literature search conducted by using PsycINFO covered the period from 1967 to November 1998 and used the key words "borderline personality disorder," "hysteroid dysphoria," "parasuicidal," "emotionally unstable," "therapy," "treatment," "psychopharmacology," "pharmacotherapy," "borderline states," "cognitive therapy," "drug therapy," "electroconvulsive shock therapy," "family therapy," "group therapy," "insulin shock therapy," "milieu therapy," "occupational therapy," "psychoanalysis," and "somatic treatment." A total of 2,460 citations were found.

An additional literature search was conducted in MEDLINE for the period from 1990 to 1999 and the key words "self mutilation" and "mental retardation." A total of 182 citations were found.

Additional, less formal literature searches were conducted by American Psychiatric Association staff and individual members of the Work Group on Borderline Personality Disorder.

NUMBER OF SOURCE DOCUMENTS

4,204

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus (Committee)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Once a topic is chosen for guideline development, a work group is formed to draft the guideline. By design, the work group consists of psychiatrists in active clinical practice with diverse expertise and practice experience relevant to the topic. Policies established by the Steering Committee guide the work of systematically reviewing data in the literature and forging consensus on the implications of those data, as well as describing a clinical consensus. These policies, in turn, stem from criteria formulated by the American Medical Association to promote the development of guidelines that have a strong evidence base and that make optimal use of clinical consensus.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Each recommendation is identified as falling into one of three categories of endorsement, indicated by a bracketed Roman numeral following the statement. The three categories represent varying levels of clinical confidence regarding the recommendation:

[I] Recommended with substantial clinical confidence.

[II] Recommended with moderate clinical confidence.

[III] May be recommended on the basis of individual circumstances.

COST ANALYSIS

The guideline developers reviewed an Australian study (1999) of a preliminary cost-benefit analysis comparing the direct cost of treatment for the 12 months preceding psychodynamic therapy with the direct cost of treatment for the 12 months following this therapy. In Australian dollars, the cost of the treatment for all patients decreased from \$684,346 to \$41,424. Including psychotherapy in the

cost of treatment, there was a total savings per patient of \$8,431 per year. This cost-effectiveness was accounted for almost entirely by a decrease in the number of hospital days. Without a control group, however, the guideline developers could not definitively conclude that the cost savings were the result of the psychotherapy.

METHOD OF GUIDELINE VALIDATION

Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

This practice guideline was developed under the auspices of the American Psychiatric Association Steering Committee on Practice Guidelines. The process is detailed in a document available from the American Psychiatric Association Department of Quality Improvement and Psychiatric Services (American Psychiatric Association guideline development process. In: practice guidelines for the treatment of psychiatric disorders: compendium 2000. Washington [DC]: American Psychiatric Association, 2000).

Key features of the process include:

- A comprehensive literature review and development of evidence tables
- Initial drafting by a work group that included psychiatrists with clinical and research expertise in borderline personality disorder
- The production of multiple drafts with widespread review, in which 13 organizations and more than 60 individuals submitted significant comments
- Approval by the American Psychiatric Association Assembly and Board of Trustees (July 2001)
- Planned revisions at regular intervals

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Each recommendation is identified as falling into one of three categories of endorsement, indicated by a bracketed Roman numeral following the statement. The three categories represent varying levels of clinical confidence regarding the recommendation.

Definition of grades of recommendation are presented at the end of the Major Recommendations field.

1. The Initial Assessment

The psychiatrist first performs an initial assessment of the patient to determine the treatment setting [1]. Because suicidal ideation and suicide attempts are common, safety issues should be given priority, and a thorough safety evaluation should be done. This evaluation, as well as consideration of other clinical factors, will determine the necessary treatment setting (e.g., outpatient or inpatient). A more comprehensive evaluation of the patient

should then be completed [1]. It is important at the outset of treatment to establish a clear and explicit treatment framework [1], which includes establishing agreement with the patient about the treatment goals.

2. Psychiatric Management

Psychiatric management forms the foundation of treatment for all patients. The primary treatment for borderline personality disorder is psychotherapy, complemented by symptom-targeted pharmacotherapy [1]. In addition, psychiatric management consists of a broad array of ongoing activities and interventions that should be instituted by the psychiatrist for all patients with borderline personality disorder [1]. Regardless of the specific primary and adjunctive treatment modalities selected, it is important to continue providing psychiatric management throughout the course of treatment. The components of psychiatric management for patients with borderline personality disorder include responding to crises and monitoring the patient's safety, establishing and maintaining a therapeutic framework and alliance, providing education about borderline personality disorder and its treatment, coordinating treatment provided by multiple clinicians, monitoring the patient's progress, and reassessing the effectiveness of the treatment plan. The psychiatrist must also be aware of and manage potential problems involving splitting and boundaries.

3. Principles of Treatment Selection

a. Type

Certain types of psychotherapy (as well as other psychosocial modalities) and certain psychotropic medications are effective in the treatment of borderline personality disorder [1]. Although it has not been empirically established that one approach is more effective than another, clinical experience suggests that most patients with borderline personality disorder will need extended psychotherapy to attain and maintain lasting improvement in their personality, interpersonal problems, and overall functioning [11]. Pharmacotherapy often has an important adjunctive role, especially for diminution of symptoms such as affective instability, impulsivity, psychotic-like symptoms, and self-destructive behavior [1]. No studies have compared a combination of psychotherapy and pharmacotherapy to either treatment alone, but clinical experience indicates that many patients will benefit most from a combination of these treatments [11].

b. Focus

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 symptoms [1].

c. Flexibility

Because comorbid disorders are often present and each patient's history is unique, and because of the heterogeneous nature of

borderline personality disorder, the treatment plan needs to be flexible, adapted to the needs of the individual patient [1]. Flexibility is also needed to respond to the changing characteristics of patients over time.

d. Role of Patient Preference

Treatment should be a collaborative process between patient and clinician(s), and patient preference is an important factor to consider when developing an individual treatment plan [1].

e. Multiple- Versus Single-Clinician Treatment

Treatment by a single clinician and treatment by more than one clinician are both viable approaches [11]. Treatment by multiple clinicians has potential advantages but may become fragmented; good collaboration among treatment team members and clarity of roles are essential [1].

4. Specific Treatment Strategies

a. Psychotherapy

Two psychotherapeutic approaches have been shown in randomized controlled trials to have efficacy: psychoanalytic/psychodynamic therapy and dialectical behavior therapy [1]. The treatment provided in these trials has three key features: weekly meetings with an individual therapist, one or more weekly group sessions, and meetings of therapists for consultation/supervision. No results are available from direct comparisons of these two approaches to suggest which patients may respond better to which type of treatment. Although brief therapy for borderline personality disorder has not been systematically examined, studies of more extended treatment suggest that substantial improvement may not occur until after approximately 1 year of psychotherapeutic intervention has been provided; many patients require even longer treatment.

Clinical experience suggests that there are a number of common features that help guide the psychotherapist, regardless of the specific type of therapy used [1]. These features include building a strong therapeutic alliance and monitoring self-destructive and suicidal behaviors. Some therapists create a hierarchy of priorities to consider in the treatment (e.g., first focusing on suicidal behavior). Other valuable interventions include validating the patient's suffering and experience as well as helping the patient take responsibility for his or her actions. Because patients with borderline personality disorder may exhibit a broad array of strengths and weaknesses, flexibility is a crucial aspect of effective therapy. Other components of effective therapy for patients with borderline personality disorder include managing feelings (in both patient and therapist), promoting reflection rather than impulsive action, diminishing the patient's tendency to engage in splitting, and setting limits on any self-destructive behaviors.

Individual psychodynamic psychotherapy without concomitant group therapy or other partial hospital modalities has some empirical support [11]. The literature on group therapy or group skills training for patients with borderline personality disorder is limited but indicates that this treatment may be helpful [11]. Group approaches are usually used in combination with individual therapy and other types of treatment. The published literature on couples therapy is limited but suggests that it may be a useful and, at times, essential adjunctive treatment modality. However, it is not recommended as the only form of treatment for patients with borderline personality disorder [11]. While data on family therapy are also limited, they suggest that a psychoeducational approach may be beneficial [11]. Published clinical reports differ in their recommendations about the appropriateness of family therapy and family involvement in the treatment; family therapy is not recommended as the only form of treatment for patients with borderline personality disorder [11].

b. Pharmacotherapy and Other Somatic Treatment

Pharmacotherapy is used to treat state symptoms during periods of acute decompensation as well as trait vulnerabilities. Symptoms exhibited by patients with borderline personality disorder often fall within three behavioral dimensions--affective dysregulation, impulsive-behavioral dyscontrol, and cognitive-perceptual difficulties--for which specific pharmacological treatment strategies can be used.

i. Treatment of affective dysregulation symptoms

Patients with borderline personality disorder displaying this dimension exhibit mood lability, rejection sensitivity, inappropriate intense anger, depressive "mood crashes," or outbursts of temper. These symptoms should be treated initially with a selective serotonin reuptake inhibitor (SSRI) or related antidepressant such as venlafaxine [1]. Studies of tricyclic antidepressants have produced inconsistent results. When affective dysregulation appears as anxiety, treatment with an selective serotonin reuptake inhibitor may be insufficient, and addition of a benzodiazepine should be considered, although research on these medications in patients with borderline personality disorder is limited, and their use carries some potential risk [11].

When affective dysregulation appears as disinhibited anger that coexists with other affective symptoms, selective serotonin reuptake inhibitors are also the treatment of choice [11]. Clinical experience suggests that for patients with severe behavioral dyscontrol, low-dose neuroleptics can be added to the regimen for rapid response and improvement of affective symptoms [11].

Although the efficacy of monoamine oxidase inhibitors (MAOIs) for affective dysregulation in patients with borderline

personality disorder has strong empirical support, monoamine reuptake inhibitors are not a first-line treatment because of the risk of serious side effects and the difficulties with adherence to required dietary restrictions [1]. Mood stabilizers (lithium, valproate, carbamazepine) are another second-line (or adjunctive) treatment for affective dysregulation, although studies of these approaches are limited [11]. There is a paucity of data on the efficacy of electroconvulsive therapy (ECT) for treatment of affective dysregulation symptoms in patients with borderline personality disorder. Clinical experience suggests that while electroconvulsive therapy may sometimes be indicated for patients with comorbid severe axis I depression that is resistant to pharmacotherapy, affective features of borderline personality disorder are unlikely to respond to electroconvulsive therapy [11].

An algorithm depicting steps that can be taken in treating symptoms of affective dysregulation in patients with borderline personality disorder is shown in Appendix 1 of the original guideline document.

ii. Treatment of impulsive-behavioral dyscontrol symptoms

Patients with borderline personality disorder displaying this dimension exhibit impulsive aggression, self-mutilation, or self-damaging behavior (e.g., promiscuous sex, substance abuse, reckless spending). Selective serotonin reuptake inhibitors (see Appendix 2 of the original guideline document) are the initial treatment of choice [1]. When behavioral dyscontrol poses a serious threat to the patient's safety, it may be necessary to add a low-dose neuroleptic to the selective serotonin reuptake inhibitor [11]. Clinical experience suggests that partial efficacy of a selective serotonin reuptake inhibitor may be enhanced by adding lithium [11]. If a selective serotonin reuptake inhibitor is ineffective, switching to a monoamine oxidase inhibitor may be considered [11]. Use of valproate or carbamazepine may also be considered for impulse control, although there are few studies of these treatments for impulsive aggression in patients with borderline personality disorder [11]. Preliminary evidence suggests that atypical neuroleptics may have some efficacy for impulsivity in patients with borderline personality disorder [11].

iii. Treatment of cognitive-perceptual symptoms

Patients with borderline personality disorder displaying this dimension exhibit suspiciousness, referential thinking, paranoid ideation, illusions, derealization, depersonalization, or hallucination-like symptoms. Low-dose neuroleptics (see Appendix 3 of original guideline) are the treatment of choice for these symptoms [1]. These medications may improve not only psychotic-like symptoms but also depressed mood, impulsivity, and anger/hostility. If response is suboptimal, the dose should

be increased to a range suitable for treating axis I disorders [11].

5. Special Features Influencing Treatment

Treatment planning and implementation should reflect consideration of the following characteristics: comorbidity with axis I and other axis II disorders, problematic substance use, violent behavior and antisocial traits, chronic self-destructive behavior, trauma and posttraumatic stress disorder (PTSD), dissociative features, psychosocial stressors, gender, age, and cultural factors [1].

6. Risk Management Issues

Attention to risk management issues is important [1]. Risk management considerations include the need for collaboration and communication with any other treating clinicians as well as the need for careful and adequate documentation. Any problems with transference and countertransference should be attended to, and consultation with a colleague should be considered for unusually high-risk patients. Standard guidelines for terminating treatment should be followed in all cases. Psychoeducation about the disorder is often appropriate and helpful. Other clinical features requiring particular consideration of risk management issues are the risk of suicide, the potential for boundary violations, and the potential for angry, impulsive, or violent behavior.

Definitions:

Grades of Recommendations

- I. Recommended with substantial clinical confidence.
- II. Recommended with moderate clinical confidence.
- III. May be recommended on the basis of individual circumstances.

CLINICAL ALGORITHM(S)

Three clinical algorithms are provided:

- Psychopharmacological Treatment of Affective Dysregulation Symptoms in Patients with Borderline Personality Disorder
- Psychopharmacological Treatment of Impulsive-Behavioral Dyscontrol Symptoms in Patients with Borderline Personality Disorder
- Psychopharmacological Treatment of Cognitive-Perceptual Symptoms in Patients with Borderline Personality Disorder

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for each recommendation (See "Major Recommendations").

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate assessment and treatment selection in patients with borderline personality disorder

POTENTIAL HARMS

Psychodynamic Therapy

Psychodynamic psychotherapy has the potential to disorganize some patients if the focus is too exploratory or if there is too much emphasis on transference without an adequately strong alliance. Intensive dynamic psychotherapy may also activate strong dependency wishes in the patient as transference wishes and feelings develop in the context of the treatment. It is the exploration of such dependency that is often essential to help the patient to achieve independence. This dependence may elicit countertransference problems in the therapist, which can lead to inappropriate or ineffective treatment. The most serious examples of this include unnecessary increases in the frequency or duration of treatment or transgression of professional boundaries.

Cognitive Behavior Therapy

Although there are no reports of adverse effects of cognitive behavior therapy, including dialectical behavior therapy, as administered on an outpatient basis, one inpatient study reported a paradoxical increase in parasuicidal acting out in the dialectical behavior therapy group compared with the control group -- a finding thought perhaps to be due to the contagion effect within a closed, intensive milieu.

Group Therapy

Acute distress from exposure to emotionally arousing group issues has been reported. Other potential risks of treating patients with borderline personality disorder in group settings include shared resistance to therapeutic work, hostile or other destructive interactions among patients, intensification of transference problems, and symptom "contagion."

Couples Therapy

One report described an escalation of symptoms when traditional marital therapy was used with a couple who both were diagnosed with borderline personality disorder. Clinical experience would indicate the need for careful psychiatric evaluation of the spouse. When severe character pathology is present in both, the clinician will need to use a multidimensional approach, providing a holding environment for both partners while working toward individuation and intrapsychic growth. Because the spouse's own interpersonal needs or behavioral patterns

may, however pathological, serve a homeostatic function within the marriage, couples therapy has the potential to further destabilize the relationship.

Family Therapy

Some clinicians report that traditional dynamically based family therapy has the potential to end prematurely and have a poor outcome, since patients may alienate their family members or leave the treatment themselves because they feel misunderstood when family involvement is indicated. A psychoeducational approach appears to be less likely to have such adverse effects; however, even psychoeducational approaches can upset family members who wish to avoid knowledge about the illness or involvement in the family member's treatment.

Selective Serotonin Reuptake Inhibitors

The side effect profile of the selective serotonin reuptake inhibitors is favorable compared with that of older tricyclic, heterocyclic, or monoamine oxidase inhibitor antidepressants, including low risk in overdose. Side effects reported in these studies are consistent with routine clinical usage.

Tricyclic and Heterocyclic Antidepressants

Common side effects of tricyclic antidepressants include sedation, constipation, dry mouth, and weight gain. The toxicity of tricyclic antidepressants in overdose, including death, indicates that they should be used with caution in patients at risk for suicide. Patients with cardiac conduction abnormalities may experience a fatal arrhythmia with tricyclic antidepressant treatment. For some inpatients with borderline personality disorder, treatment with amitriptyline has paradoxically been associated with behavioral toxicity, consisting of increased suicide threats, paranoid ideation, demanding and assaultive behaviors, and an apparent disinhibition of impulsive behavior.

Monoamine Oxidase Inhibitors

Phenelzine can cause weight gain and can be difficult to tolerate. Other side effects include orthostatic hypotension. Fatal hypertensive crises are the most serious potential side effect of monoamine oxidase inhibitors, although no study reported any hypertensive crises due to violation of the tyramine dietary restriction. The initial clinical picture of monoamine oxidase inhibitor poisoning is one of agitation, delirium, hallucinations, hyperreflexia, tachycardia, tachypnea, dilated pupils, diaphoresis, and, often, convulsions. Hyperpyrexia is one of the most serious problems.

Lithium Carbonate and Anticonvulsant Mood Stabilizers

Although lithium commonly causes side effects, most are minor or can be reduced or eliminated by lowering the dose or changing the dosage schedule. More common side effects include polyuria, polydipsia, weight gain, cognitive problems (e.g., dulling, poor concentration), tremor, sedation or lethargy, and gastrointestinal distress (e.g., nausea). Lithium may also have renal effects and

may cause hypothyroidism. Lithium is potentially fatal in overdose and should be used with caution in patients at risk of suicide.

Carbamazepine's most common side effects include neurological symptoms (e.g., diplopia), blurred vision, fatigue, nausea, and ataxia. Other side effects include skin rash, mild leukopenia or thrombocytopenia, and hyponatremia. Rare, idiosyncratic, but potentially fatal side effects include agranulocytosis, aplastic anemia, hepatic failure, exfoliative dermatitis, and pancreatitis. Carbamazepine may be fatal in overdose. In studies of patients with borderline personality disorder, carbamazepine has been reported to cause melancholic depression.

Common dose-related side effects of valproate include gastrointestinal distress (e.g., nausea), benign hepatic transaminase elevations, tremor, sedation, and weight gain. With long-term use, women may be at risk of developing polycystic ovaries or hyperandrogenism. Mild, asymptomatic leukopenia and thrombocytopenia occur less frequently. Rare, idiosyncratic, but potentially fatal adverse events include hepatic failure, pancreatitis, and agranulocytosis.

Anxiolytics

Behavioral disinhibition, resulting in impulsive and assaultive behaviors, has been reported with alprazolam in patients with borderline personality disorder. Benzodiazepines, in general, should be used with care because of the potential for abuse and the development of pharmacological tolerance with prolonged use. These are particular risks in patients with a history of substance use.

Neuroleptics

Dropout rates in neuroleptic trials in borderline outpatients range from 13.7% for a 6-week trial to 48.3% for a 12-week trial to 87.5% for a 22-week continuation study. In acute studies, patient nonadherence is often due to typical medication side effects, e.g., extrapyramidal symptoms, akathisia, sedation, and hypotension. Patients with borderline personality disorder who have experienced relief of acute symptoms with low-dose neuroleptics may not tolerate the side effects of the drug with longer-term treatment. The risk of tardive dyskinesia must be considered in any decision to continue neuroleptic medication over the long term. Thioridazine has been associated with cardiac rhythm disturbances related to widening of the Q-T interval and should be avoided. In the case of clozapine, the risk of agranulocytosis is especially problematic. While the newer atypical neuroleptics promise a more favorable side effect profile, evidence of efficacy in borderline personality disorder is still awaited. Neuroleptics should be given in the context of a supportive doctor-patient relationship in which side effects and nonadherence are addressed frequently.

Subgroups Most Likely to be Harmed:

- Some studies suggest ethnic groups may differ in their response to psychotropic medications and antidepressants. Asians, for example, may require lower doses of haloperidol and have higher serum levels of haloperidol after oral administration than Caucasian patients.
- Diagnosis should be made with care with adolescents whose personalities are still developing.

- Elderly patients are particularly prone to certain medication side effects (e.g., orthostatic hypotension and anticholinergic effects).

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

This report is not intended to be construed or to serve as a standard of medical care. Standards of medical care are determined on the basis of all clinical data available for an individual case and are subject to change as scientific knowledge and technology advance and patterns evolve. These parameters of practice should be considered guidelines only. Adherence to them will not ensure a successful outcome in every case, nor should they be construed as including all proper methods of care or excluding other acceptable methods of care aimed at the same results. The ultimate judgment regarding a particular clinical procedure or treatment plan must be made by the psychiatrist in light of the clinical data presented by the patient and the diagnostic and treatment options available.

This practice guideline has been developed by psychiatrists who are in active clinical practice. In addition, some contributors are primarily involved in research or other academic endeavors. It is possible that through such activities some contributors have received income related to treatments discussed in this guideline. A number of mechanisms are in place to minimize the potential for producing biased recommendations due to conflicts of interest. The guideline has been extensively reviewed by members of American Psychiatric Association as well as by representatives from related fields. Contributors and reviewers have all been asked to base their recommendations on an objective evaluation of available evidence. Any contributor or reviewer who has a potential conflict of interest that may bias (or appear to bias) his or her work has been asked to notify the American Psychiatric Association Department of Quality Improvement and Psychiatric Services. This potential bias is then discussed with the work group chair and the chair of the Steering Committee on Practice Guidelines. Further action depends on the assessment of the potential bias.

The guideline reviews the treatment that patients with borderline personality disorder may need. Psychiatrists care for patients in many different settings and serve a variety of functions and thus should either provide or recommend the appropriate treatment for patients with borderline personality disorder. In addition, many patients have comorbid conditions that may need treatment. Therefore, psychiatrists caring for patients with borderline personality disorder should consider, but not be limited to, treatments recommended in this guideline.

Issues in Interpreting the Literature

The following issues should be considered when interpreting the literature presented in the guideline on the efficacy of treatments for borderline personality disorder. Virtually all of the studies involved adults with borderline personality disorder. While the results may be applicable to adolescents, there is a paucity of research that has examined the efficiency of these treatments for this age group. Although some of these treatments have been evaluated through randomized, placebo-controlled trials, the gold standard for determining treatment efficacy,

information for other treatments is available only from case reports, case series, or retrospective studies, which limits the conclusions that can be drawn about treatment efficacy.

Another consideration is that efficacy studies (e.g., placebo-controlled trials) have notable strengths but also some limitations. Although such studies are necessary to establish that a particular treatment is effective, there may be limits to how generalizable the study findings are. For example, inclusion and exclusion criteria result in particular types of patients being involved in a study. When reviewing the data presented in the guideline, clinicians should consider how similar their patient is to the population included in a particular study. This is particularly important because of the heterogeneous nature of borderline personality disorder symptoms. Some studies, for example, select patients with marked impulsivity, whereas others include patients with prominent affective features. In addition, many studies have been relatively short term; longer-term treatment outcome studies are needed.

Another issue to consider is that some studies are done in specialized research settings with more expertise and training in the treatment modality than is generally available in the community. In addition, the amount of treatment provided in a study may be greater than is actually available in the community.

When evaluating studies of psychosocial treatments that consist of multiple elements, such as psychodynamic psychotherapy, it may be difficult to know which elements are responsible for the treatment outcome. Another factor to consider is that patients in certain studies of psychosocial treatment were also taking prescription medication, and no steps were taken to control for these effects. Conversely, patients in some studies of medication efficacy also received psychotherapy, and no steps were taken to control for these effects. Therefore, the literature on the efficacy of any one particular treatment is often confounded by the presence of other simultaneous treatments. It can be difficult, then, to isolate the impact of a single modality in most treatment efficacy studies involving patients with borderline personality disorder.

In clinical practice, a combination of treatment approaches is often used and appropriate. Few data are available on the complex treatment regimens often required by the realities of clinical practice (e.g., the use of multiple medications simultaneously). Many clinically important and complex treatment questions have not been (and are unlikely to ever be) addressed in research studies. For such questions, clinical consensus is the best available guide.

In women of childbearing age, pregnant and nursing women, the risks of treatment with medication must be carefully weighed against the potential risks and benefits of alternative or no treatment. For example, anticonvulsants are associated with a potential risk of birth defects, and the risk of birth defects from other psychotropic medications is unknown. Psychiatrists should encourage careful contraceptive practice for all female patients of childbearing age who are receiving pharmacological treatment. Since carbamazepine can increase the metabolism of birth control pills, the dosage of contraceptives may need to be adjusted accordingly.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better

IOM DOMAIN

Effectiveness
Patient-centeredness
Safety

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Practice guideline for the treatment of patients with borderline personality disorder. American Psychiatric Association. Am J Psychiatry 2001 Oct; 158(10 Suppl): 1-52. [198 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2001 Oct

GUIDELINE DEVELOPER(S)

American Psychiatric Association - Medical Specialty Society

SOURCE(S) OF FUNDING

American Psychiatric Association (APA)

GUIDELINE COMMITTEE

Work Group on Borderline Personality Disorder

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Work Group Members: John M. Oldham, M.D., (Chair); Katharine A. Phillips, M.D. (Consultant); Glen O. Gabbard, M.D.; Marcia K. Goin, M.D., Ph.D.; John Gunderson, M.D.; Paul Soloff, M.D.; David Spiegel, M.D.; Michael Stone, M.D.

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

This practice guideline has been developed by psychiatrists who are in active clinical practice. In addition, some contributors are primarily involved in research or other academic endeavors. It is possible that through such activities many contributors have received income related to treatments discussed in this guideline. A number of mechanisms are in place to minimize the potential for producing biased recommendations due to conflicts of interest. The guideline has been extensively reviewed by members of American Psychiatric Association (APA) as well as by representatives from related fields. Contributors and reviewers have all been asked to base their recommendations on an objective evaluation of the available evidence. Any contributor or reviewer has a potential conflict of interest that may bias (or appear to bias) his or her work has been asked to notify the APA Office of Research. This potential bias is then discussed with the work group chair and the chair of the Steering Committee on Practice Guidelines. Further action depends on the assessment of the potential bias.

GUIDELINE STATUS

This is the current release of the guideline.

An update is not in progress at this time.

GUIDELINE AVAILABILITY

Electronic copies: Available from the [American Psychiatric Association Web site](#).

Print copies: Available from the American Psychiatric Press, Inc (APPI), 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209-3901; (703) 907-7322; (800) 368-5777; Fax (703) 907-1091. Order No. 2319. Additional ordering information is available from the [American Psychiatric Press, Inc. Web site](#).

AVAILABILITY OF COMPANION DOCUMENTS

The following is available:

- American Psychiatric Association practice guideline development process. In: practice guidelines for the treatment of psychiatric disorders: compendium 2000. Washington (DC): American Psychiatric Association, 2000.

Print copies: Available from the American Psychiatric Press, Inc (APPI), 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209-3901; (703) 907-7322; (800) 368-5777; Fax (703) 907-1091. Order No. 2319. Additional ordering information is available from the [American Psychiatric Press, Inc. Web site](#).

PATIENT RESOURCES

None available

NGC STATUS

This summary was completed by ECRI on January 7, 2002. The information was verified by the guideline developer as of January 31, 2002.

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