ACA-PBs
American Counseling Association Practice Briefs
The Center for Counseling Practice, Policy, and Research
counseling.org/practice_briefs | 703-823-9800 x324

December 2014

Borderline Personality Disorder

Laura R. Haddock, Walden University

DESCRIPTION OF BORDERLINE PERSONALITY DISORDER

Borderline personality disorder (BPD) is a mental health disorder defined in the *DSM-5* (American Psychiatric Association [APA], 2013) as a pervasive pattern of instability in interpersonal relationships, self-image, and affect that involves impulsive behavior and difficulties in regulating emotions. These difficulties typically result in impulsive actions and chaotic interpersonal relationships. Other symptoms include extreme fears of abandonment and episodes of self-mutilation and suicidality; the National Institute of Health (NIH) reports that as many as 80% of individuals diagnosed with BPD experience suicidal ideation and about 4–9% commit suicide (National Institute of Mental Health, n.d.). Identified as one of the more commonly diagnosed personality disorders (Torgersen, 2009), researchers suggest that BPD is present in approximately one percent of the general population (Lenzeenweger, Lane, Lonanger, & Kessler, 2007), about 20% of clients receiving inpatient psychiatric treatment (Gunderson & Links, 2008), and 10% of individuals receiving outpatient mental health services (National Education Alliance, 2014).

Resource:

National Institute of Mental Health. (n.d.). Borderline personality disorder. Retrieved from http://www.nimh.nih.gov/health/topics/borderline-personality-disorder/index.shtml

IDENTIFICATION/ASSESMENT STRATEGIES

It is important to note that personality disorders are associated with the weakest diagnostic reliability and are the most frequently misdiagnosed category of diagnoses in the *DSM* classification system (Chmielewski & Watson, 2010; Kress & Paylo, 2015). The following assessment tools can be used to identify the presence and severity of symptoms associated with BPD. As with any assessment, it is important for counselors to be familiar with the psychometric and multicultural properties of each instrument in order to choose one that is most appropriate for individual clients.

Borderline Symptom Checklist-23 (BSL-23)

The Borderline Symptom List (BSL-95) was initially developed as a self-rating instrument for specific assessment of borderline-typical symptoms. The internal consistency of the BSL-23 is high with a reported Cronbach's: 0.94-0.97. The BSL-23 is an efficient and convenient self-rating instrument that displays very good psychometric properties comparable to those of the full version of the BSL.

Resources:

Bohus, M., Kleindienst, N., Linberger, M., Stieglitz, R., Domsolla, M. Chapman, A., …Wolf, M. (2009). The short version of the Borderline Symptom List (BSL-23): developmentand initial data on psychometric properties. *Psychopathology, 42*, 32-39. doi: 10.1159/000173701 University of Washington (n.d.). *Behavioral Research and Therapy Clinic.* Retrieved from: http://blogs.uw.edu/brtc/publications-assessment-instruments

Difficulties in Emotion Regulation Scale (DERS)

The DERS is a 36-item self-report measure that assesses difficulties in regulation emotion, among adults and adolescents. Constructs assessed include nonacceptance of emotional response, difficulties engaging in goal-directed behavior, impulse-control difficulties, lack of emotional awareness, limited access to emotion regulation, and lack of emotional clarity.

Resource:

Gratz, K. L., & Roemer, L. (2004). Multidimensional assessment of emotion regulation and dysregulation: Development, factor structure, and initial validation of the Difficulties in Emotion Regulation Scale. *Journal of Psychopathology and Behavioral Assessment, 26*, 41−54. Retrieved from: http://www.springer.com/psychology/journal/10862

International Personality Disorder Examination (IPDE)

This measure is used to identify personality disorders including BPD. The IPDE is the most widely established measure of personality disorders currently available and is used by the World Health Organization. Inter-rater reliability for BPD diagnosis on the IPDE has been found to range from .73 to .89 and its historical stability ranges from .56 to .84. This measure may not be practical for clinicians as it is long and somewhat cumbersome and requires specific training to administer and score.

Resource:

Loranger, A. W. (1995). *International Personality Disorder Examination (IPDE) Manual.* White Plains, NY: Cornell Medical Center.

Longitudinal Interview Follow-up Evaluation—Psychiatric Status Ratings (LIFE)

This measure evaluates the presence and severity of psychiatric diagnoses over time. The LIFE can be used as a measure of quality-of-life-interfering behavior that is common in individuals with BPD. High interviewer-observer reliability has been shown for the change points in diagnostic criteria as well as for the level of psychopathology.

Resource:

Keller, M. B., Lavori, P. W., Friedman, B., Nielsen, E. C., Endicott, J., McDonald-Scott, P., … Andreasen, N. C. (1987). The longitudinal interval follow-up evaluation: A comprehensive method for assessing outcome in prospective longitudinal studies. *Archives of General Psychiatry*, *44*, 540-548. Retrieved from: http://www.ncbi.nlm.nih.gov/pubmed/3579500

Millon Clinical Multi-Axial Inventory III (MCMI-III)

This instrument is designed to help assess a number of *DSM* disorders. The current edition of the assessment is composed of 175 true/false questions and was designed for administration with adults (over 18) who have a minimum of an eighth grade reading level. This instrument has a test-retest reliability of .91.

Resource:

Millon, T., Millon, C., Davis, R., & Grossman, S. (2009). *MCMI-III Manual* (4th ed.). Minneapolis, MN: Pearson.

Personality Diagnostic Questionnaire-Revised (PDQ-R)

The Personality Diagnostic Questionnaire-Revised-is a 99 item, self-administered, true/false questionnaire that indicates personality disorder diagnoses consistent with the *DSM-IV* diagnostic criteria. It takes approximately 20-30 minutes to complete this assessment. It is widely used in clinical and research settings. It has been criticized for overdiagnosing the presence of personality disorders. Due to its high false positive rates, it may be more appropriately used as a screening tool, rather than a standalone diagnostic tool.

Resource:

Hyler, S. E., Oldham, J. M, Kellman, H. D., & Doidge, N. (1992). Validity of the Personality Diagnostic Questionnaire-Revised: A Replication in an Outpatient Sample. *Comprehensive Psychiatry, 33,* 73-77. Retrieved from: http://www.ncbi.nlm.nih.gov/pubmed/1544299

INTERVENTION STRATEGIES

There is a great deal of literature available related to the treatment of borderline personality disorder and researchers suggest that BPD may be less responsive to treatment interventions than other types of personality disorders (Butcher, Mineka, & Hooley, 2010). One issue that complicates the measurement of treatment effectiveness for BPD is the high incidence of comorbidity among those with personality disorders (Zimmerman, Rothchild, & Chelminski, 2005). Women diagnosed with BPD often show a higher incidence of major depression, anxiety disorders, or eating disorders, while men are commonly also diagnosed with substance abuse disorders and antisocial personality disorder (National Institute of Mental Health, n.d.). In addition, neurobiological factors and childhood trauma have also been identified as elements which potentially contribute to the development of borderline personality disorder (Brandelow, et al., 2005) and can complicate treatment approaches. Finally, due to symptom variations in meeting diagnostic criteria, clients may present with very different features of the disorder (Johansen, Karterud, Pedersen, Gude, & Falkum, 2004), and a careful and thorough medical exam may also be used to help rule out physiological causes for symptoms. Overall, it is clear that BPD is complex in both development and identification, and no single therapeutic approach can be used to diagnose this disorder.

Psychotherapy is widely considered to be the treatment of choice in treating BPD (American Psychiatric Association Practice, 2001; Kendall et al., 2009) as opposed to psychopharmacotherapy and other treatment approaches. A number of therapeutic approaches and treatments have empirical support in treating BPD (Gunderson, 2011). Researchers suggest that Dialectical Behavior Therapy (DBT) and other specified cognitive behavioral and behavior therapy interventions may be most effective in treating BPD (Goldman & Gregory, 2010; Gunderson, 2011; Kliem, Kroger, & Kosfelder, 2010; Linehan et al., 2002).

Interventions for BPD may be delivered in an individual or group setting. Some interventions, such as DBT, integrate both individual and group treatment into the therapeutic regimen. Group therapy sessions offer the benefit of allowing individuals with BPD an opportunity to improve effective self-expression and interact with others in appropriate ways. Overall, features common to all successful evidence-based treatments include validation of the client's experience and a firmly-established therapeutic alliance. In addition, the assessment and monitoring of high risk behaviors with an emphasis on client safety are also common to effective interventions (Kress & Paylo, 2015).

Dialectical Behavior Therapy (DBT)

DBT is the most well-researched and efficacious therapeutic intervention for the treatment of BPD (Goldman & Gregory, 2010; Gunderson, 2011; Kliem, Kroger, & Kosfelder, 2010; Linehan et al., 2002). DBT is a cognitive behavior therapy specifically developed for the treatment of BPD and it has been found to reduce emotional dysregulation and assist in isolating and amending core beliefs and behaviors that motivate erroneous perceptions of self and others (Linehan,1993; Linehan et al., 2006). DBT may help address a range of mood and anxiety symptoms and decrease suicidal or self-harming behaviors (Davidson et al., 2008; Linehan et al., 2006; Verheul et al., 2003).

The central premise of DBT is the assertion that individuals with DBT struggle to tolerate and regulate strong emotional states. The goal of DBT is to teach healthy coping skills in order to help clients manage intense emotions without the use of self-destructive behavior. The ideal result is improved emotional regulation and healthier relationships.

Grounded in a support-oriented approach, DBT emphasizes each individual's unique strengths so that clients may feel capable of facilitating change. DBT is also a collaborative approach which places persistent attention on the therapeutic relationship in an effort to facilitate trust and encourage client commitment to the therapeutic plan. This approach is quite active requiring clients to complete homework assignments, role play and routinely practice new ways of thinking and behaving in both individual and group therapy sessions. Clients must also learn and practice techniques for self-soothing and frustration tolerance. Counselors use mindfulness concepts and meditation, regulated breathing and relaxation to teach clients to become more self-aware and attentive to situations. DBT promotes a balance between changing destructive behaviors and practicing acceptance of beliefs and behaviors (McMain & Pos, 2007).

DBT is a long-term therapy approach which incorporates both individual and group therapy and generally requires clients to commit to 6-12 months of treatment. A treatment team is utilized in treatment planning and meets regularly to collaborate and discuss progress. Individual therapy is typically one hour per week focusing on individual needs and the client's application of improved coping skills in real world events. The individual treatment is combined with 2 or more hours of weekly group treatment focused on learning and applying new coping skills related to distress tolerance, interpersonal relationships and learning to regulate negative emotions. In addition to the individual and group therapy, DBT includes phone coaching between sessions in an effort to interrupt self-injurious or suicidal behaviors.

Resources:

Behavioral Tech, LLC—www.behavioraltech.org

Linehan, M. (1993). *Cognitive behavioral treatment of borderline personality disorder*. New York, NY: Guilford.

McKay, M., Wood, J., & Brantley, J. (2007). *The dialectical behavior therapy skills workbook: Practical DBT exercises for learning mindfulness, interpersonal effectiveness, emotional regulation and distress tolerance*. Oakland, CA: New Harbinger.

Schema-Focused Therapy

Schema Focused Therapy (SFT) integrates cognitive behavioral, experiential, interpersonal and psychoanalytic therapies into one united model. SFT has some evidence to suggest that it is an effective model for treating BPD (Young, Klosko, & Weishaar, 2003). However, because SFT it is an integrated approach it is a difficult treatment to evaluate as there are no standard treatment applications. The outcomes of some studies suggest that SFT has effectively decreased personality dysfunction, improved quality of life, and reduced self-harming behaviors (Giesen-Bloo et al., 2006; Farrell, Shaw, & Webber, 2009).

SFT is grounded on the premise that early relationships are commonly internalized and produce maladaptive cognitive-affective representations. Individuals with BPD are seen as having regressive reactive emotional states that mirror those they had as children. The treatment addresses the cognitive schemas that originate in childhood and ultimately solidify as dysfunctional core elements of the adult personality. SFT addresses five primary modes of reactive schemas including: (1) the abandoned and abused child; (2) the angry and impulsive child; (3) the detached protector; (4) the punitive parent; and (5) the healthy adult (Kellogg & Young, 2006). As individuals with BPD routinely demonstrate dysfunctional and inappropriate interpersonal reactivity, SFT seeks to modify these responses through the incorporation of interventions from a variety of models. SFT is also a long-term therapy and clients are routinely referred for two sessions of weekly therapy for an average duration of three years (Arntz, van Genderen, & Drost, 2009). An empathic therapeutic relationship is emphasized. SFT addresses enduring and self-defeating patterns of thought and behavior while attempting to help clients reframe their self-concept. Homework is routinely utilized, as is role play to facilitate dialog between schema modes. This therapy is founded on the premise that those with BPD have a dysfunctional self-image that impacts interpersonal relationships, coping skills, and reactivity to events and their environment (Kellogg & Young, 2006).

Resource:

Young, J., Klosko, J., & Weishaar, M. (2006). *Schema Therapy: A practitioner's guide*. New York, NY: Guilford.

Systems Training for Emotional Predictability and Problem Solving (STEPPS)

Though long-term therapy is the preferred treatment approach for the treatment of BPD (Zanarini, 2009), STEPPS is designed as a relatively brief group therapy intervention which includes 20, two-hour sessions with specific weekly goals (Blum, Pfohl, St. John, Monahan, & Black, 2002). STEPPS has demonstrated effective treatment for BPT in randomized controlled trials including reducing depression and impulsivity and improving overall functioning (Blum et al., 2008).

This cognitive behavioral systems-based group treatment focuses not only on the client but also on their system (i.e., family members or significant others). In preliminary studies, researchers have found that clients with BPD have demonstrated some improvement in reducing depression and self-destructive behaviors associated with BPD and improving quality of life (Blum et al., 2008).

Resource:
Agency for Healthcare Research and Quality http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/rrs/

REFERENCES

American Psychiatric Association (APA). (2013). *Diagnostic and statistical manual of mental disorders [DSM-V]* (5th ed.). Washington, DC: Author.

American Psychiatric Association Practice. (2001). Practice guideline for the treatment of patients with borderline personality disorder. *American Journal of Psychiatry, 158*, 1-52. doi:10.1176/appi.books.9780890423363.54853

Arntz, A., van Genderen, H., & Drost, J. (2009). *Schema therapy for borderline personality disorder*. Malden, MA: Wiley.

Blum, N., Pfohl, B., St. John, D., Monahan, P., & Black, D. (2002). STEPPS: A cognitive behavioral systems based group treatment for outpatients with borderline personality disorder – a preliminary report. *Comprehensive Psychiatry, 43*, 301- 310. Retrieved from: http://www.ncbi.nlm.nih.gov/pubmed/12107867

Blum, N., St. John, B., Pfohl, B., Stuart, S., McCormick, B., Allen, J., … Black, D.(2008). Training for Emotional Predictability and Problem Solving (STEPPS) for outpatients with borderline personality disorder: A randomized controlled trial and 1 year follow-up. *American Journal of Psychiatry, 165*, 468-478. doi: 10.1176/appi.ajp.2007.07071079

Bohus, M., Kleindienst, N., Linberger, M., Stieglitz, R., Domsolla, M. Chapman, A., …Wolf, M. (2009). The short version of the Borderline Symptom List (BSL-23): development and initial data on psychometric properties. *Psychopathology, 42*, 32-39. doi: 10.1159/000173701

Brandelow, B., Krause, J., Wedekind, D., Broocks, A., Hajak, G., & Ruther, E. (2005). Early traumatic life events, parental attitudes, family history, and birth risk factors in patients with borderline personality disorder and healthy controls. *Psychiatry Research,* 134, 169-179. Retrieved from: http://www.ncbi.nlm.nih.gov/pubmed/15840418

Butcher, J. N., Mineka, S., & Hooley, J. M. (2010). *Abnormal psychology* (14th ed.). New York, NY: Allyn & Bacon.
Chmielewski, M., & Watson, D. (2008). The heterogeneous structure of schizotypal personality disorder: Item-level factors of the schizotypal personality questionnaire and their associations with obsessive compulsive disorder symptoms, dissociative tendencies, and normal personality. *Journal of Abnormal Psychology, 117*, 364–376. doi: 10.1037/0021-843X.117.2.364

Davidson, K., Norrie, J., Tyere, P., Gurnley, A., Tata, P., Murray, H., … Palmer, S (2008). The effectiveness of cognitive behavior therapy for borderline personality disorder: Results from the borderline personality disorder study of cognitive therapy trial. *Journal of Personality Disorders, 20*, 450-465. doi:10.1521/pedi.2006.20.5.450

Farrell, J., Shaw, I., & Webber, M. (2009). A schema focused approach to group psychotherapy for outpatients with borderline personality disorder: A randomized controlled trial. *Journal of Behavior Therapy & Experimental Psychiatry*, *40*, 317-328. doi: 10.1016/j.jbtep.2009.01.002

Giesen-Bloo, J., van Dyck, R., Spinhoven, P., van Tilburg, W.,Dirksen, C.; van Asselt, T., … Arntz, A. (2006). Outpatient psychotherapy for borderline personality disorder. *Archives of General Psychiatry, 63*, 649-658. doi:10.1001/archpsyc.63.6.649.

Goldman, G., & Gregory, R. (2010). Relationships between techniques and outcomes for borderline personality disorder. *American Journal of Psychotherapy, 64*(4), 359-371. Retrieved from: http://www.ncbi.nlm.nih.gov/pubmed/21299173

Gratz, K. L., & Roemer, L. (2004). Multidimensional assessment of emotion regulation and dysregulation: Development, factor structure, and initial validation of the Difficulties in motion Regulation Scale. *Journal of Psychopathology and Behavioral Assessment*, *26*, 41−54. Retrieved from: http://www.springer.com/psychology/journal/10862

Gunderson, J. G. (2011). Borderline personality disorder. *New England Journal of Medicine, 364*, 2037-2042. doi: 10.1056/NEJMcp1007358

Gunderson, J. G., & Links, P. S. (2008). *Borderline personality disorder: A clinical guide* (2nd ed.). Arlington, VA: American Psychiatric Publishing, Inc.

Hyler, S. E., Oldham, J. M, Kellman, H. D., & Doidge, N. (1992). Validity of the Personality Diagnostic Questionnaire- Revised: A replication in an outpatient sample. *Comprehensive Psychiatry*, *33*, 73-77. Retrieved from: http://www.ncbi.nlm.nih.gov/pubmed/1544299

Johansen, M., Karterud, S., Pedersen, G., Gude, T., & Falkum, E. (2004). An investigation of the prototype validity of the borderline DSM-IV construct. *Acta Psychiatrica Scandinavica*, *109*, 289–298. Retrieved from: http://www.ncbi.nlm.nih.gov/pubmed/15008803

Keller, M. B., Lavori, P. W., Friedman, B., Nielsen, E. C., Endicott, J., McDonald-Scott, P., & Andreasen, N. C. (1987). The longitudinal interval follow-up evaluation: A comprehensive method for assessing outcome in prospective longitudinal studies. *Archives of General Psychiatry*, *44*, 540-548. Retrieved from: http://www.ncbi.nlm.nih.gov/pubmed/3579500

Kellogg, S., & Young, J. (2006). Schema therapy for borderline personality disorder. *Journal of Clinical Psychology*, *62*(4), 445-58. doi: 10.1002/jclp.20240

Kendall, T., Pilling, S., Tyrer, P., Duggan, C., Burbeck, R., Meader, N., & Taylor C. (2009). Borderline and antisocial personality disorders: Summary of NICE guidance. *British Medical Journal, 338*, b93. doi: 10.1136/bmj.b93

Kliem, S., Kroger, C., & Kosfelder, J. (2010). Dialectical behavior therapy for borderline personality disorder: A meta-analysis using mixed-effects modeling. *Journal of Consulting and Clinical Psychology, 78*, 936–951. doi: 10.1037/a0021015

Kress, V. E., & Paylo, M. J. (2015). *Treating those with mental disorders: A comprehensive approach to case conceptualization and treatment.* New York, NY: Pearson.

Lenzeenweger, M. F., Lane, M. C., Lonanger, A. W., & Kessler, R. C. (2007). DSM-IV personality disorders in the national comorbidity survey replication. Retrieved from http://www.nimh.nih.gov/statistics/pdf/NCS-R_Borderline_Personality_Disorder.pdf

Linehan, M. (1993). *Cognitive behavioral treatment of borderline personality disorder.* New York, NY: Guilford.

Linehan, M., Armstrong, A., Suarez, A., Allmon, D., & Heard, H. (1991). Cognitive behavioral treatment of chronically parasuicidal borderline patients. *Archives of General Psychiatry, 48*(12), 1060-1064. doi:10.1001/archpsyc.1991.01810360024003

Linehan, M. M., Comtois, K. A., Murray, A. M., Brown, M. Z., Gallop, R. J., Heard, H. L., … Lindenboim, N. (2006). Two-year randomized controlled trial and follow-up of dialectical behavior therapy vs. therapy by experts for suicidal behaviors and borderline personality disorder. *Archives of General Psychiatry*, *63*, 757–766. Retrieved from: http://www.ncbi.nlm.nih.gov/pubmed/16818865

Linehan, M., Dimeff, L., Renolds, S., Comtois, K., Welch, S. Heagerty, P., … Kivlahan, D. (2002). Dialectical therapy versus comprehensive validation therapy plus 12-step for the treatment of opiod dependent women meeting criteria for borderline personality disorder. *Drug and Alcohol Dependence, 67*(1), 13-26. Retrieved from: http://www.ncbi.nlm.nih.gov/pubmed/12062776

Loranger, A. W. (1995). *International personality disorder examination (IPDE) manual.* White Plains, NY: Cornell Medical Center.

McKay, M., Wood, J., & Brantley, J. (2007). *The dialectical behavior therapy skills workbook: Practical DBT exercises for learning mindfulness, interpersonal effectiveness, emotional regulation and distress tolerance.* Oakland, CA: New Harbinger.

McMain, S., & Pos, A. (2007). Advances in psychotherapy of personality disorders: A research update. *Current Psychiatry Reports, 9*, 46-52. Retrieved from: http://www.ncbi.nlm.nih.gov/pubmed/17257514

Millon, T., Millon, C., Davis, R., & Grossman, S. (2009). *MCMI-III manual* (4th ed.). Minneapolis, MN: Pearson Education, Inc.

National Education Alliance Borderline Personality Disorder. (2014). About borderline personality disorder (BPD). Retrieved from http://www.borderlinepersonalitydisorder.com/what-is-bpd/bpd-overview/

National Institute of Mental Health. (n.d.). Borderline personality disorder. Retrieved from http://www.nimh.nih.gov/health/topics/borderline-personality-disorder/index.shtml

Torgersen, S. (2009). The nature (and nurture) of personality disorders. *Scandinavian Journal of Psychology, 50,* 624–632. doi:10.1111/j.1467-9450.2009.00788.x

Tyrer, P., & Mulder, R. (2006). Management of complex and severe personality disorders in community mental health services. *Current Opinion in Psychiatry, 19*(4), 400–404. Retrieved from: http://www.ncbi.nlm.nih.gov/pubmed/16721171

Verheul, R., Van Den Bosch, L. M. C., Koeter, M. W. J., De Ridder, M. A. J., Stijnen, T., & Van Den Brink, W. (2003). Dialectical behaviour therapy for women with borderline personality disorder: 12-month, randomized clinical trial in the Netherlands. *The British Journal of Psychiatry*, *182*, 135–140. Retrieved from: http://www.ncbi.nlm.nih.gov/pubmed/12562741

Young, J. E., Klosko, J. S., & Weishaar, M. E. (2003). *Schema therapy: A practitioner's guide.* New York, NY: Guilford.

Zanarini, M. C. (2009). Psychotherapy of borderline personality disorder. *Acta Psychiatrica Scandinavica, 120*(5), 373 – 377. doi: 0.1111/j.1600-0447.2009.01448.x

Zimmerman, M., Rothchild, L., & Chelminski, I. (2005). The prevalence of DSM-IV personality disorders in psychiatric outpatients. *American Journal of Psychiatry*, *162*, 1911–1918. Retrieved from: http://www.ncbi.nlm.nih.gov/pubmed/16199838