An Introduction to Co-Occurring Borderline Personality Disorder and Substance Use Disorders

This *In Brief* is for health and human services professionals (e.g., social workers, vocational counselors, case managers, healthcare providers, probation officers). It is intended to introduce such professionals to borderline personality disorder (BPD)—a condition with very high rates of suicide and self-harm that often co-occurs with substance use disorders (SUDs). This *In Brief* presents the signs and symptoms of BPD, with or without a co-occurring SUD, alerts professionals to the importance of monitoring clients with BPD for self-harm and suicidal behavior, and encourages professionals to refer such clients for appropriate treatment. This *In Brief* is not meant to present detailed information about BPD or treatment guidelines for BPD or SUDs.

What Is Borderline Personality Disorder?

BPD is one among several *personality disorders* (e.g., narcissistic personality disorder, paranoid personality disorder, antisocial personality disorder). According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5), personality disorders are generally characterized by:

- Entrenched patterns of behavior that deviate significantly from the usual expectations of behavior of the individual’s culture.
- Behavior patterns that are pervasive, inflexible, and resistant to change.
- Emergence of the disorder’s features no later than early adulthood (unlike depression, for example, which can begin at any age).
- Lack of awareness that behavior patterns and personality characteristics are problematic or that they differ from those of other individuals.
- Distress and impairment in one or more areas of a person’s life (often only after other people get upset about his or her behavior).
- Behavior patterns that are not better accounted for by the effects of substance abuse, medication, or some other mental disorder or medical condition (e.g., head injury).

BPD is a complex and serious mental illness. Individuals with BPD are often misunderstood and misdiagnosed. A history of childhood trauma (e.g., physical or sexual abuse, neglect, early parental loss) is more common for individuals with BPD. In fact, many individuals with BPD may have developed BPD symptoms as a way to cope with childhood trauma. However, it is important to note that not all individuals with BPD have a history of childhood trauma. It is also important to note that some of the symptoms of BPD overlap with those of several other DSM-5 diagnoses, such as bipolar disorder and posttraumatic stress disorder (PTSD). Therefore, a diagnosis of BPD should be made only by a licensed and experienced mental health professional (whose scope of practice includes diagnosing mental disorders) and then only after a thorough assessment over time.

Individuals with BPD often require considerable attention from their therapists and are generally considered to be challenging clients to treat. However, BPD may not be the chronic disorder it was once thought to be. Individuals with

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**How Common Is BPD?**

Estimates of BPD prevalence in the U.S. population range from 1.6 percent to 5.9 percent. BPD affects approximately 10 percent of all psychiatric outpatients and up to 20 percent of all inpatients.
BPD often respond to appropriate treatment and may have a good long-term prognosis,\textsuperscript{1,5} experiencing a remission of symptoms with a relatively low occurrence of relapse.\textsuperscript{6,7} The DSM-5 indicates that BPD is diagnosed more often in women than in men (75 percent and 25 percent, respectively).\textsuperscript{1} Other research, however, has suggested that there may be no gender difference in prevalence in the general population,\textsuperscript{5,6} but that BPD is associated with a significantly higher level of mental and physical disability for women than it is for men.\textsuperscript{6} In addition, the types of co-occurring conditions tend to be different for women than for men. In women, the most common co-occurring disorders are major depression, anxiety disorders, eating disorders, and PTSD. Men with BPD are more likely to have co-occurring SUDs and antisocial personality disorder, and they are more likely to experience episodes of intense or explosive anger.\textsuperscript{8,9}

### What Are the Symptoms of BPD?

The DSM-5 classifies mental disorders and includes specific diagnostic criteria for all currently recognized mental disorders. It is a tool for diagnosis and treatment, but it is also a tool for communication, providing a common language for clinicians and researchers to discuss symptoms and disorders. According to the DSM-5, the symptoms of BPD include:\textsuperscript{1}

- Intense fear of abandonment and efforts to avoid abandonment (real or imagined).
- Turbulent, erratic, and intense relationships that often involve vacillating perceptions of others (from extremely positive to extremely negative).
- Lack of a sense of self or an unstable sense of self.
- Impulsive acts that can be hurtful to oneself (e.g., excessive spending, reckless driving, risky sex).
- Repeated suicidal behavior or gestures or self-mutilating behavior. (See the section below on suicide and nonsuicidal self-injury.)
- Chronic feelings of emptiness.
- Episodes of intense (and sometimes inappropriate) anger or difficulty controlling anger (e.g., repeated physical fights, inappropriate displays of anger).
- Temporary feelings of paranoia (often stress-related) or severe dissociative symptoms (e.g., feeling detached from oneself, trancelike).

Anyone with some of these symptoms may need to be referred to a licensed mental health professional for a complete assessment. Exhibit 1 presents some examples of how a person with BPD might behave.

### Suicide and nonsuicidal self-injury

BPD is unique in that it is the only mental disorder diagnosis that includes suicide attempts or self-harming behaviors among its diagnostic criteria.\textsuperscript{3} The risk of suicide is high among individuals with BPD, with as many as 79 percent reporting a history of suicide attempts\textsuperscript{10} and 8 percent to 10 percent dying by suicide—a rate that may be 50 times greater than the rate among the general population.\textsuperscript{11} More than 75 percent of individuals with BPD engage in deliberate self-harming behaviors known as nonsuicidal self-injury (NSSI) (e.g., cutting or burning themselves).\textsuperscript{12} Unlike suicide attempts, NSSI does not usually involve a desire or intent to die. Sometimes the person with BPD does not consider these behaviors harmful.\textsuperscript{4} One study involving 290 patients with BPD found that 90 percent of patients reported a history of NSSI, and over 70 percent reported the use of multiple methods of NSSI.\textsuperscript{10} Reasons for NSSI vary from person to person and, for some individuals, there may be more than one reason. The behaviors may be:\textsuperscript{4,13,14}

- A way to express anger or pain.
- A way to relieve pain (i.e., shifting from psychic pain to physical pain).
- A way to “feel” something.
- A way to “feel real.”
- An attempt to regulate emotions.
- A form of self-punishment.
- An effort to get attention or care from others.

NSSI may include:\textsuperscript{4,13,14}

- Cutting.
- Burning.
- Skin picking or excoriation.
Exhibit 1. Examples of Symptomatic Behavior (BPD)

- **Patterns of intense and unstable relationships**
  John comes in to see his case manager, George, and announces that he plans to marry a woman he met at a speed-dating event the night before. George has heard this same story from John at least once a month for the past 4 months.

- **Emotions that seem to change quickly from one extreme to another**
  Suzie has been working with a vocational rehabilitation counselor, Tony, for 2 weeks to prepare for job retraining. One day, just after Tony gets everything set up for Suzie to begin her training, Suzie storms out of the office screaming at him, “You’re just trying to get rid of me! You don’t understand me at all! I hate you!” Later, when Tony calls to suggest that maybe Suzie would prefer to work with another counselor, Suzie begins to cry and says, “Please don’t drop me, Tony! I need you!”

- **Evidence of self-harm or self-mutilation**
  José is a probation officer. During his weekly appointment with his client, Annie, José notices a pattern of recent cuts across her left forearm. José asks her about them, and Annie becomes defensive and says, “Okay, I cut myself sometimes, so what? It’s none of your business. I’m not hurting anybody!”

- **Pattern of suicidal thoughts, gestures,* or attempts**
  Maria is a nurse. As she looks over the health history of her new patient, Sally, she notices that Sally has been hospitalized three times in the past 4 years after suicide attempts, and that she has seen six different therapists. Sally tells her, “Yeah, I get suicidal sometimes. I just can’t seem to find the right therapist who can help me.”

- **Intense displays of emotion that often seem inappropriate or out of proportion to the situation**
  Regina is a social worker at a domestic violence shelter. She notices one of her clients, Elena, sitting in the living room with a sketchpad in her lap. Regina asks if she can see what Elena is drawing. Elena turns the sketchpad around to reveal a beautiful, detailed drawing of the shelter house. Regina admires it and says how beautiful it is, then says, “That’s funny, I thought that the house number was on the right side of the door.” Elena, who had been smiling, takes the sketchpad from Regina, looks at the drawing, then rips it from the pad and begins tearing it up, saying, “You’re right, it’s all wrong! I’ll have to start all over again!”

*Regarding the word *gestures*: It is dangerous to dismiss or label *any* suicidal behavior as a gesture. Anyone who exhibits suicidal thoughts or behaviors of any kind needs to be assessed by a licensed mental health professional.

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**What Are the Symptoms of SUDs?**
SUDs involve patterns of recurrent substance use that result in significant problems, which fall into the following categories:

- **Head banging.**
- **Hitting.**
- **Hair pulling.**

**Impaired control**—taking more of the substance than intended, trying unsuccessfully to cut down on use, spending an increasing amount of time obtaining and using the substance, craving or having a strong desire for substance use

**Social impairment**—failing to fulfill obligations at work, school, or home; continuing substance use in spite of the problems it causes; giving up or reducing other activities because of substance use

**Risky use**—using the substance(s) in situations in which it may be physically dangerous to do so (e.g., driving) or in spite of physical or psychological problems that may have been caused or may be made worse by substance use (e.g., liver problems, depression)

**Pharmacological criteria**—displaying symptoms of *tolerance* (need for increased amounts of the substance to achieve the desired effect) or *withdrawal* (a constellation of physical symptoms that occurs when the use of the substance has ceased)
What Is the Relationship Between BPD and SUDs?

One study\textsuperscript{15} found that the prevalence of BPD among individuals seeking buprenorphine treatment for opioid addiction exceeded 40 percent, and another\textsuperscript{16} found that nearly 50 percent of individuals with BPD were likely to report a history of prescription drug abuse. A large survey\textsuperscript{6} found that 50.7 percent of individuals with a lifetime diagnosis (i.e., meeting the criteria for a diagnosis at some point during the individual’s life) of BPD also had a diagnosis of an SUD over the previous 12 months. This same survey found that for individuals with a lifetime diagnosis of an SUD, 9.5 percent also had a lifetime diagnosis of BPD. This is a significantly higher incidence of BPD than that in the general public, which ranges from 1.6 percent to 5.9 percent.\textsuperscript{1}

One longitudinal study\textsuperscript{17} found that 62 percent of patients with BPD met criteria for an SUD at the beginning of the study. However, over 90 percent of patients with BPD and a co-occurring SUD experienced a remission of the SUD by the time of the study’s 10-year follow-up. (Remission was defined as any 2-year period during which the person did not meet criteria for an SUD.) The authors also looked at whether there were recurrences of SUDs after periods of remission and found that the rate of recurrence was 40 percent for alcohol and 35 percent for drugs. The rate of new onsets of SUDs, while lower than expected, was still 21 percent for drugs and 23 percent for alcohol. Another study\textsuperscript{18} found that individuals with BPD had higher rates of new SUD onsets even when their BPD symptoms improved (compared with new SUD onsets for individuals with other personality disorders).

A client with BPD and a co-occurring SUD presents some particular challenges. BPD is difficult to treat, partly because of the pervasive, intractable nature of personality disorders and partly because clients with BPD often do not adhere to treatment and often drop out of treatment. The impulsivity, suicidality, and self-harm risks associated with BPD may all be exacerbated by the use of alcohol or drugs.\textsuperscript{19} In addition, the presence of BPD may contribute to the severity of SUD symptoms,\textsuperscript{20} and the course of SUD treatment may be more complicated for clients who also have BPD.\textsuperscript{21}

Who Can Best Provide Treatment for People With BPD and SUDs?

Individuals who display some of the symptoms of BPD (as described above) should be referred to an experienced licensed mental health professional for a thorough mental health assessment and possible referral to treatment. It is important to know whether referral sources have experience treating clients with BPD. If individuals display symptoms of substance misuse, they should also be assessed for a co-occurring SUD.

Individuals with BPD sometimes trigger intense feelings of frustration and even anger in their therapists and other providers.\textsuperscript{12} Clients with BPD often have difficulty developing good relationships, including productive working relationships with therapists and other providers (e.g., healthcare workers, case managers, vocational counselors). Some individuals with BPD may move from therapist to therapist (or other professionals) in an effort to find “just the right person.”

Individuals who have an SUD may receive treatment from an individual counselor or therapist or from an outpatient treatment program. However, a co-occurring diagnosis of BPD may complicate SUD treatment. It is important for the professionals treating the person for either diagnosis to work in consultation with each other.

Treatment for BPD—especially with a co-occurring SUD—sometimes involves a team approach. Depending on the treatment plan, a person may have an individual therapist, a group therapist, a substance abuse counselor, a psychiatrist, and a primary care provider; treatment may need to be planned and managed through the coordinated efforts of all providers. Regular consultation among all providers can ensure that everyone is working toward the same goals from each of their professional perspectives. For example:

- In individual therapy sessions, a therapist may help the client learn to tolerate gradually increasing levels of uncomfortable emotions (e.g., stress, anxiety) so that the client may begin to have more control over those emotions.
- A psychiatrist may consider the use of medication for the client or evaluate currently prescribed medications to determine adherence and their effect on the client’s ability to engage in the emotional work of therapy.
A substance abuse counselor may work with the client to achieve abstinence, identify relapse triggers that may come up as the client does emotional work in therapy, and identify coping strategies for remaining abstinent.

A vocational counselor may need to work with the client on distress tolerance as it relates to employment issues, such as applying for jobs or beginning a new job. This may mean helping the client understand the importance of being at interviews, vocational training classes, or work on time (even if emotional problems make that difficult) and helping the client develop strategies to achieve a pattern of good work habits.

Some people with BPD may consciously or unconsciously attempt to sabotage treatment by providing conflicting information to providers or by trying to turn one provider against another. Consultation among all providers can help deter this.

What Treatments Are Available for Individuals With BPD and SUDs?

Many studies have been done on treatment approaches for BPD or SUDs, but very few have involved participants with co-occurring BPD and SUDs. However, based on the studies that have been done on co-occurring BPD and SUDs, a few approaches seem to show promise. Perhaps the most researched approach is Dialectical Behavior Therapy, which has been adapted for treatment of co-occurring BPD and SUDs (Dialectical Behavior Therapy-S [DBT-S]).

It is important to note, however, that DBT-S and other promising approaches involve structured, manualized treatments that are quite intensive and require a significant amount of training and resources (e.g., staffing, space, finances) that may not be available in all areas. Many therapists work on their own with individuals who have BPD, using the best techniques that their training and experience have to offer—hopefully in regular consultation with an experienced clinical supervisor. Therapists often adapt psychotherapy to better meet the needs of an individual client, sometimes combining different therapeutic approaches or mixing techniques. However, for clients with both BPD and SUDs, the therapist may need to work with an SUD treatment provider to provide comprehensive care.

Pharmacotherapy for BPD and SUDs

The Food and Drug Administration (FDA) has not approved any medications for the treatment of BPD. However, individuals with BPD may take medications to alleviate some of their symptoms. For example, selective serotonin reuptake inhibitors may be prescribed for depressed mood, irritability, anger, and impulsivity.

There are several FDA-approved medications for SUD treatment. For alcohol use disorder, these include acamprosate, disulfiram, and naltrexone. For opioid use disorder, approved medications include buprenorphine, a combination of buprenorphine and naloxone, methadone, and naltrexone. Some of these medications may be prescribed on a short-term basis (e.g., to ease withdrawal symptoms, lessen cravings), and others may be prescribed for long-term use (e.g., to facilitate longer periods of abstinence).

Individuals may receive their prescriptions and medication management from a psychiatrist, from other types of healthcare providers, or from both (or, in the case of methadone, from an opioid treatment program). Individuals may take medication as one part of a treatment plan that also includes attending individual therapy, group therapy, group skill-building sessions, or a mutual-help group (e.g., 12-step program), or some combination of these.

What Are Some Things To Remember When Working With Someone Who Has Co-Occurring BPD and SUDs?

Some of the same guidelines that have been identified as necessary for mental health professionals who work with clients who have these two diagnoses may also be helpful for all human services professionals. Working with a client who has co-occurring BPD and SUDs requires:

- **Strong (but not rigid) professional boundaries**—Be clear with the person about the expectations in the working relationship (e.g., length of appointments, level of support, contact outside regular appointments). Be aware of special requests to make exceptions.
to the usual rules for working with clients. These requests sometimes escalate over time. If in doubt about making an exception to the rules, discuss the situation with a supervisor who is knowledgeable about working with individuals who have BPD (within applicable confidentiality requirements).\textsuperscript{11}

- **A commitment to self-care**—If possible, schedule appointments with someone who has BPD right before lunch or before a break. Avoid scheduling back-to-back appointments with two individuals who have BPD. It is important to have some time between them to see clients with other diagnoses, to work on other tasks, or simply to take a break. Develop the habit of leaving work at work (i.e., don’t “replay” interactions with individuals who have BPD).

- **An awareness of how BPD may affect any kind of work with the individual**—For example, fearing abandonment and avoiding abandonment are characteristics of BPD and may manifest in some unexpected ways. For example, if the professional relationship has focused on the person with BPD completing certain goals, that person may thwart his or her own progress to avoid the feelings of abandonment that would result from ending the working relationship.

- **Knowledge about what skills the individual who has BPD is learning in therapy**—The person may need assistance applying those new skills to broader life situations. For example, perhaps one skill the person has learned is how to break down a seemingly overwhelming task into a series of small steps. Work with the person to apply that particular skill to the situation at hand.

**Conclusions**

It is important to remember that:

- Most human services professionals will encounter clients with BPD in the course of their work.

- Individuals with BPD often have co-occurring diagnoses (e.g., depression, SUDs).

- BPD is often characterized by intense emotional displays and impulsive acts (e.g., self-harm, suicide attempts).

- Working with an individual with BPD (with or without a co-occurring SUD) can be challenging.

- Individuals with BPD (with or without a co-occurring SUD) deserve to receive appropriate treatment and deserve to be treated with compassion and respect.

- Individuals with BPD often respond to appropriate treatment and experience a remission of symptoms with a relatively low occurrence of relapse.

- Individuals with BPD (with or without a co-occurring SUD) may have a team of professionals who provide different aspects of care (e.g., therapist, psychiatrist).

- It is important for all professionals involved in the care of an individual with BPD to communicate and work together.

**Resources**

**SAMHSA resources**

National Registry of Evidence-based Programs and Practices
http://nrepp.samhsa.gov

Treatment Improvement Protocols (TIPs)
(see back page for electronic access and ordering information)

- TIP 36: *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues*

- TIP 42: *Substance Abuse Treatment for Persons With Co-Occurring Disorders*

- TIP 44: *Substance Abuse Treatment for Adults in the Criminal Justice System*

- TIP 50: *Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment*

**Web resources**

- American Psychiatric Association
http://www.psych.org

- American Psychological Association
http://www.apa.org

- Borderline Personality Disorder Resource Center
http://bpdresourcecenter.org
Notes


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Treating Borderline Personality Disorder

Discrimination and Barriers to Treatment

Individuals with a diagnosis of BPD are subject to a great deal of discrimination and bias, both in society at large and within the mental health treatment community. Characteristics of BPD, particularly anger, suicidality, and a tendency to vacillate between extremes of idealization and devaluation, have contributed to a common view among many clinicians that individuals with BPD are “difficult,” “noncompliant,” “manipulative,” “troublemakers.” “unresponsive,” “impossible,” and numerous other pejorative descriptions.8,26,xiv

In the preface to his 2008 book *Treatment of Borderline Personality Disorder: A Guide to Evidence-Based Practice*,68 Paris articulates the reasons that many providers simply will not treat individuals with BPD or significant borderline symptoms.23,xv

Paris wrote:

> Patients with borderline personality disorder (BPD) …. can challenge even the most experienced therapists. The most frightening symptoms of BPD are chronic suicidal ideation, repeated suicide attempts, and self-mutilation. These are the patients we worry about—and are afraid of losing. …All too frequently, [BPD] is diagnosed as a variant of major depression or bipolar

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disorder. Moreover, patients with BPD are often mistreated. They receive prescriptions for multiple drugs that provide only marginal benefit. They do not always get the evidence-based psychotherapy they need. (p. vii-viii)

The symptoms that make treating clients with BPD so challenging for many professionals are the same that make it difficult for so many of those diagnosed with the illness to maintain a treatment relationship despite a desire for recovery. Just as borderline symptoms contribute heavily to unstable and stormy interpersonal relationships, they can have the same impact on the therapeutic relationship. Many clinicians report challenges in establishing the rapport and alliance necessary for effective treatment, which can be a contributing factor to many individuals’ terminating the therapeutic relationship early.

**Suicide Risk**

BPD carries an 8-10 percent rate of death by suicide, which is 50 times greater than in the general population. More than 70 percent of individuals with BPD will attempt suicide at least once. Suicide attempts tend to peak when consumers are in their 20s and 30s, though suicidality is not by any means restricted to these age groups. In addition, the estimated rate of self-harm (i.e., self-destructive behaviors such as cutting or other self-injury with no suicidal intent) is as high as 60-80 percent of those with the diagnosis. The constant fear of a client’s suicide, whether intentional or accidental, is extremely concerning and stressful for clinicians, and managing this risk is of the utmost importance to maintain client safety.

**Evidence-Based Practices for Borderline Personality Disorder**

SAMHSA’s National Registry of Evidence-Based Programs and Practices (NREPP) lists two evidence-based practices for this disorder: dialectical behavior therapy and psychoeducational multifamily groups, which are described below along with other interventions used to treat BPD. The literature identifies a number of additional treatments and techniques supported with some empirical base. Borderline personality disorder is “the only major psychiatric disorder for which psychosocial interventions remain the primary treatment”, but medication has proven a useful

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supplement to therapy in many cases. Regardless of the specific treatment, effective case management is critical and should be part of the training for every psychologist and psychiatrist.\textsuperscript{vii}

\textbf{Psychotherapeutic Interventions}

Although the specific techniques used vary among the most commonly applied therapeutic approaches to BPD, there are a number of common factors linking them:\textsuperscript{23}

\begin{itemize}
\item A clear framework for treatment that outlines expectations and boundaries for both the clinician and the client;
\item Frequent (often biweekly) contact over a period of a year or longer;
\item Close attention to the clinician-client relationship and discussion thereof as central to treatment;
\item Development of skills and coping mechanisms to manage impulsivity and emotional dysregulation; and
\item A progressive approach to treatment that follows essentially a three-step pattern: (1) stabilizing the client, (2) understanding how past experiences inform current behaviors, and (3) reorganizing and reconceptualizing thoughts and behaviors affecting interpersonal relationships.
\end{itemize}

\textbf{Dialectical Behavior Therapy (DBT).} DBT has a large empirical base compared with other treatments and is largely considered one of the best, if not the best, treatments for BPD. DBT is a type of cognitive-behavior therapy pioneered by Marsha Linehan in the early 1990s.\textsuperscript{68,75-79} It combines weekly individual therapy with weekly group skills training in mindfulness (i.e., awareness of present experiences), distress tolerance, emotion regulation, and interpersonal effectiveness over a period of at least 12 months. Clinicians complete intensive training to learn how to provide DBT and adhere closely to Linehan’s treatment manual. Between DBT therapy sessions, individuals complete homework assignments geared toward improving and reinforcing the new skills they learn. SAMHSA’s NREPP identifies DBT as an evidence-based practice.

Because training can be expensive and the treatment itself is resource intensive, some clinicians may provide DBT-like treatments or implement elements of DBT to improve functioning even if they do not provide formal DBT.\textsuperscript{68} However, in conducting interviews for this report, we heard concerns...

\textsuperscript{vii}P. Hoffman, Ph.D., J. Gunderson, M.D., B. Palmer, B. Elliott, J. Hall, T. Woodward, and J. Payne representing the National Education Alliance for Borderline Personality Disorder, personal communication, January 6, 2010.
expressed about clinicians who purport to be offering DBT but whose services lacked fidelity to the model and thus were not attaining the outcomes found in the controlled research studies xviii,xix. The development of a DBT certification program is one potential solution to this problem. Whereas some aspects of DBT may leave room for customization or adaptation, it is important to identify those specific characteristics and interventions that must remain consistent for providers to ensure fidelity to the core model. Clearly, this is an important issue meriting further attention and discussion in the field.

**Systems Training for Emotional Predictability and Problem Solving (STEPPS).** Similar to DBT, STEPPS is another manual-based type of cognitive-behavior therapy that combines skills training with cognitive-behavioral techniques.68,80-82 In the STEPPS model, participants meet once a week for 2 hours in groups of 6-10 with two leaders and complete weekly homework assignments. The program lasts 20 weeks and focuses on emotion management and behavioral self-management to help individuals learn effective coping methods to replace destructive patterns. A core component of STEPPS is the “reinforcement team” of family, friends, and significant others. These individuals receive training to help support the individual during times of distress or crisis. STEPPS has demonstrated effectiveness in multiple studies.80,82 It has also been implemented in correctional facilities in the Midwest to help inmates reenter society after involvement in the criminal justice system.81

**Cognitive Analytic Therapy (CAT).** Although literature from U.S. researchers is largely silent on the topic of cognitive analytic therapy,83 research from the United Kingdom and Australia points to this approach as promising, particularly when coupled with the evidence-based practice of intensive case management.67 In CAT, the individual diagnosed with BPD and the clinician create a shared understanding of the individual’s problems and difficulties, and how those issues may have developed in the individual’s life. They then work together to replace problematic patterns, behaviors, and thoughts with more effective coping mechanisms. Because of its collaborative nature and integrative approach, CAT is particularly effective in helping clients with BPD to better manage comorbid conditions such as other Axis I and II disorders and substance use disorders.

**Mentalization-Based Therapy (MBT).** MBT is a type of individual psychodynamic psychotherapy that focuses on improving individuals’ ability to make sense of their own emotions

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and the emotions of others—that is, to identify emotions correctly and learn how to respond appropriately.\textsuperscript{68,84,85} It is based on the idea that most people learn how to understand emotions and develop attachments during childhood, but whether for biological or environmental reasons, individuals with BPD did not develop this skill and need to learn it later in life. The typical recommended treatment duration is 18 months, but studies in the U.S. and abroad have also shown long-term effectiveness by using MBT as a short-term intervention.

**Transference-Focused Therapy (TFT).** TFT is another type of individual psychodynamic psychotherapy. It resembles traditional psychoanalysis in many ways in that it analyzes and reframes individuals’ emotional understanding. In this approach, clinicians help individuals identify and correct distorted perceptions. Data on its effectiveness show mixed results,\textsuperscript{68} but some studies have found evidence that TFT is effective for improving control of impulsivity and reducing suicidality.\textsuperscript{75}

**Pharmacologic Interventions**

Although there is no drug approved by the U.S. Food and Drug Administration specifically for treatment of BPD, some “personality dimensions” such as anger and impulsivity can be improved with pharmacotherapy targeted toward specific symptoms.\textsuperscript{72} Pharmacotherapy can also relieve symptoms of comorbid Axis I and II disorders, which may make it easier to treat the underlying BPD. The APA practice guideline for BPD discusses seven main classes of drugs that include antidepressants, mood stabilizers, anxiety agents, opiate agonists, and others. Selective serotonin reuptake inhibitors (SSRIs), monoamine oxidase inhibitors (MAOIs), and tricyclic and heterocyclic antidepressants are among those used most commonly.

**Family Psychoeducation**

Family therapy and family psychoeducation are related but not identical, and both can be useful for some individuals with BPD and their families. For the purposes of this report, family can refer to both the biological family and what might be called the “family of choice,” which includes spouses, romantic partners, close friends, roommates, or others who form the individual’s personal support network.

In traditional family therapy, the focus is on helping the family to function better as a unit, which may include developing family coping skills around one or more members’ behaviors and needs.
Family psychoeducation also works to improve functioning in the family unit, but in this intervention the focus is on helping the family to understand their loved one’s illness, learn techniques to cope with problematic behaviors, and play an active role in the treatment and recovery process. Family psychoeducation often equips family members with the skills to set and enforce boundaries; manage crises; and create a supportive, validating, and recovery-focused environment.

Whereas clinicians report that treating individuals with BPD is frequently stressful—particularly as a result of threats of suicide, suicide attempts, and the intense anger often associated with the disorder—these issues touch families directly and in deeply personal ways. Family members report feeling “helpless,” “hopeless,” “overwhelmed,” “angry,” and “excluded,” and they frequently experience discrimination and bias similar to that expressed toward individuals with the diagnosis. Family members also report feeling “blamed” by the treatment community for a child or other loved one’s illness.

Engaging family members is particularly important because “family members’ feelings of exclusion…coupled with their lack of awareness of how to react to the client’s pathology [i.e., behaviors or symptoms] will make the task of effectively treating the client more difficult”. Studies indicate that successful therapeutic interaction with families has a positive correlation with substantially better client outcomes. In addition, when they understand their loved one’s illness and treatment, family members can develop the coping skills they need to maintain their own mental health by setting boundaries; eliminating blame; and dealing with reasonable feelings of frustration, anger, fear, or sadness surrounding the diagnosis of BPD.

Two of the more well-known family psychoeducation programs that serve family members of individuals diagnosed with BPD are Family Connections (FC), provided by the National Education Alliance for Borderline Personality Disorder (NEA-BPD) and Family-to-Family (F2F), provided by the National Alliance on Mental Illness (NAMI). FC groups are led by trained leaders who are themselves family members, or by specially trained therapists, and is manualized. It is specific to BPD, and there is a small charge for materials. F2F, on the other hand, provides information and support for other Axis I and Axis II disorders in addition to BPD and is free of charge. Groups are led by trained family members. Both FC and F2F are 12-week group interventions. These and other family psychoeducation programs provide knowledge to participants about their loved one’s disorder, while empowering family members with practical strategies for problem solving and managing day-to-day challenges.
Consumers and experts in peer support and trauma-informed care praise a multifaceted approach to treatment—a “whole village” approach that encompasses comprehensive treatment, peer support, family support, and knowledgeable clinicians. Psychoeducation is an important vehicle for improving the effectiveness of family support and needs to be made more widely available. SAMHSA’s NREPP identifies psychoeducational multi-family groups as an evidence-based practice.

**Recovery**

Despite the frequent severity of symptoms and extremely high rate of suicide and self-injury associated with BPD, this diagnosis has a very positive prognosis. Up to three-quarters of individuals diagnosed with BPD will experience measurable improvement with treatment, with many of the most debilitating and high-risk symptoms abating significantly. 

The 2003 McLean Study of Adult Development (MSAD) followed adults with BPD for 6 years, conducting an assessment at baseline and every 2 years thereafter. The participants were men and women who were admitted to McLean Hospital in Belmont, Massachusetts, for inpatient treatment sometime between 1992 and 1995 and who met diagnostic criteria for BPD. At 2-year follow-up, 34.5 percent of participants no longer met study criteria for BPD; at 6-year follow-up, the number climbed to 68.6 percent; and at one or more subsequent follow-up periods, 73.5 percent no longer met study criteria for BPD. Of those who no longer met study criteria after 2 and 4 years, only 6 percent again met study criteria for BPD at 6-year follow-up.

These findings were consistent with the 2002 Collaborative Longitudinal Personality Disorders Study (CLPS), which reported that 59 percent of participants with a diagnosis of BPD met fewer than 5 criteria for BPD for each of 12 consecutive months after baseline assessment, as reported by participants at 6- and 12-month follow-on assessments. All study participants were either in or seeking treatment, or had a previous treatment history. Armed with such encouraging evidence, one researcher deemed BPD “the good prognosis diagnosis.”

The MSAD study reported the greatest decline in impulsive symptoms, with the least in affective symptoms. Cognitive and interpersonal symptoms were intermediate over time. What Zanarini et al. identify as “acute” symptoms, such as suicidal behavior and self-harm, were quickest to resolve.

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whereas “temperamental” symptoms such as unstable relationships and chronic anger and fear of abandonment were much slower. It is important to note that individuals who no longer meet the diagnostic criteria for the disorder may still experience one or more significant symptoms. Results of small-scale, short-term studies suggest that individuals who have been diagnosed with BPD can have substantial difficulty in certain areas of functioning, especially socially, for anywhere from 6 months to 7 years after diagnosis.