



Australian Government

**National Health and
Medical Research Council**

RESCINDED

This publication was rescinded by National Health and Medical Research Council
and is available on the Internet ONLY for historical purposes.

Important Notice

**This notice is not to be erased and must be included on any
printed version of this publication.**

This publication was rescinded by the National Health and Medical Research Council. The National Health and Medical Research Council has made this publication available on its Internet Archives site as a service to the public for historical and research purposes ONLY.

Rescinded publications are publications that no longer represent the Council's position on the matters contained therein. This means that the Council no longer endorses, supports or approves these rescinded publications.

The National Health and Medical Research Council gives no assurance as to the accuracy or relevance of any of the information contained in this rescinded publication. The National Health and Medical Research Council assumes no legal liability or responsibility for errors or omissions contained within this rescinded publication for any loss or damage incurred as a result of reliance on this publication.

Every user of this rescinded publication acknowledges that the information contained in it may not be accurate, complete or of relevance to the user's purposes. The user undertakes the responsibility for assessing the accuracy, completeness and relevance of the contents of this rescinded publication, including seeking independent verification of information sought to be relied upon for the user's purposes.

Every user of this rescinded publication is responsible for ensuring that each printed version contains this disclaimer notice, including the date of rescision and the date of downloading the archived Internet version.



Australian Government

National Health and Medical Research Council

CLINICAL PRACTICE GUIDELINE FOR THE MANAGEMENT OF BORDERLINE PERSONALITY DISORDER



Australian Government

National Health and Medical Research Council

Clinical Practice Guideline for the
Management of Borderline Personality Disorder

2012

Printed document

© Commonwealth of Australia 2013

This work is copyright. You may reproduce the whole or part of this work in unaltered form for your own personal use or, if you are part of an organisation, for internal use within your organisation, but only if you or your organisation do not use the reproduction for any commercial purpose and retain this copyright notice and all disclaimer notices as part of that reproduction. Apart from rights to use as permitted by the *Copyright Act 1968* or allowed by this copyright notice, all other rights are reserved and you are not allowed to reproduce the whole or any part of this work in any way (electronic or otherwise) without first being given the specific written permission from the Commonwealth to do so. Requests and inquiries concerning reproduction and rights are to be sent to Strategic Communications, National Health and Medical Research Council, GPO Box 1421, Canberra ACT 2601 or via e-mail to nhmrc.publications@nhmrc.gov.au.

ISBN Print: 1864965649

Electronic document

© Commonwealth of Australia 2013

This work is copyright. You may download, display, print and reproduce the whole or part of this work in unaltered form for your own personal use or, if you are part of an organisation, for internal use within your organisation, but only if you or your organisation do not use the reproduction for any commercial purpose and retain this copyright notice and all disclaimer notices as part of that reproduction. Apart from rights to use as permitted by the *Copyright Act 1968* or allowed by this copyright notice, all other rights are reserved and you are not allowed to reproduce the whole or any part of this work in any way (electronic or otherwise) without first being given the specific written permission from the Commonwealth to do so. Requests and inquiries concerning reproduction and rights are to be sent to Strategic Communications, National Health and Medical Research Council, GPO Box 1421, Canberra ACT 2601 or via e-mail to nhmrc.publications@nhmrc.gov.au.

ISBN Online: 1864965657

Published: February 2013

Publication approval

These guidelines were approved by the Chief Executive Officer of the National Health and Medical Research Council (NHMRC) on 25 October 2012, under Section 7(1)(a) of the *National Health and Medical Research Council Act 1992*. In approving these guidelines the NHMRC considers that they meet the NHMRC standard for clinical practice guidelines. This approval is valid for a period of five years.

Suggested citation

National Health and Medical Research Council. *Clinical Practice Guideline for the Management of Borderline Personality Disorder*. Melbourne: National Health and Medical Research Council; 2012.

Disclaimer

This document is a general guide to appropriate practice, to be followed subject to the clinician's judgement and patient's preference in each individual case. The guideline is designed to provide information to assist decision-making and is based on the best available evidence at the time of development of this publication.

Contact:

National Health and Medical Research Council
16 Marcus Clarke Street
Canberra ACT 2601

GPO Box 1421
Canberra ACT 2601

Phone: 61 2 6217 9000
Fax: 61 2 6217 9100
Email: nhmrc@nhmrc.gov.au
Web: www.nhmrc.gov.au

Available from: www.nhmrc.gov.au/guidelines/publications/mh25

NHMRC Reference code: MH25

Table of contents

Abbreviations	vii
Special terms used in this document	viii
Summary	1
About borderline personality disorder (BPD)	1
Making the diagnosis of BPD	1
Treatments for BPD	2
Making our health system work better for people with BPD	3
Supporting families, partners and carers of people with BPD	3
General principles of BPD care for all health professionals	4
Executive Summary	5
About the recommendations	5
Key recommendations	6
Full list of recommendations	9
1. Introduction	19
1.1 Purpose of this guideline	19
1.2 Intended users of this guideline	19
1.3 Target population	19
1.4 Healthcare settings to which this guideline applies	20
1.5 Background	20
1.6 The clinical need for this guideline	21
1.7 Methods used to develop this guideline	22
1.8 Scheduled review of this guideline	31
1.9 Funding	31
2. Background	33
2.1 The diagnostic construct	33
2.2 Theories on the aetiology and pathogenesis of BPD	33
2.3 Trauma and BPD	34
2.4 Treatment goals for people with BPD	35
2.5 Considerations when interpreting the evidence	37
3. Managing risk factors and preventing BPD	39
3.1 Risk factors for BPD	39
3.2 Preventing BPD	42

4. Identifying and assessing BPD	43
4.1 Overview: diagnostic assessment for BPD	43
4.2 Identifying BPD features in young people	46
4.3 Diagnostic tools and assessments for BPD in young people	48
4.4 Clinical and resource implications for recommendations 1–7: identifying and assessing BPD	49
5. Managing BPD	51
5.1 Psychological therapies for BPD	51
5.2 Pharmacotherapy for BPD	59
5.3 Targeting specific outcomes	66
5.4 Complementary therapies for BPD	79
5.5 Delivery modes for BPD treatments	79
5.6 Multimodal treatments for BPD	80
5.7 BPD treatment for adolescents	82
5.8 Managing co-occurring health conditions in people with BPD	85
5.9 Managing complex and severe BPD	89
5.10 Cost-effectiveness of BPD treatments	90
5.11 Clinical and resource implications for recommendations 8–30: managing BPD	91
6. Organising healthcare services to meet the needs of people with BPD	93
6.1 Effectiveness and safety of BPD treatment delivered by different types of healthcare services	93
6.2 Effectiveness of treatments according to service type	95
6.3 Role of acute inpatient care	95
6.4 Role of long-term inpatient care	97
6.5 Role of specialised BPD services	98
6.6 Roles of various health professionals in BPD care	99
6.7 Coordinating care for people with BPD	102
6.8 Supporting health professionals who care for people with BPD	103
6.9 Clinical and resource implications for recommendations 31–50: organising healthcare services to meet the needs of people with BPD	106
7. Supporting families, partners and carers	107
7.1 Influence of families, partners and carers on BPD	107
7.2 Interventions directed at families, partners and carers to support the care of a person with BPD	109
7.3 Needs of families, partners and carers	112
7.4 Interventions to meet families', partners' and carers' needs	116
7.5 Clinical and resource implications for recommendations 51–63: supporting families, partners and carers	120
8. General principles for treatment and care of people with BPD	121
8.1 Gaining trust and managing emotions	121
8.2 Setting boundaries	123
8.3 Managing transitions and endings	123
8.4 Developing a BPD management plan	124
8.5 Assessing and managing risk of self-harm or suicide	126

9. Areas for future research	133
9.1 Risk Factors and prevention	133
9.2 Identifying and assessing BPD	133
9.3 Managing BPD	133
9.4 Organising services	134
9.5 Supporting families, partners and carers	134
10. Templates and resources	135
10.1 BPD management plan template	137
10.2 BPD crisis management plan template	141
11. Clinical questions	145
11.1 Identifying and assessing BPD	145
11.2 Managing risk factors and preventing BPD	145
11.3 Managing BPD	145
11.4 Organising healthcare services to meet the needs of people with BPD	146
11.5 Supporting families and carers	146

Appendices

(see separate document available from: <http://www.nhmrc.gov.au/guidelines/publications/mh25>)

List of tables

Table i.	Definitions of types of recommendations	5
Table ii.	Definition of grades for evidence-based recommendations	6
Table 1.1	The need for improved BPD services in Australia	22
Table 1.2	Committee membership	23
Table 1.3	Declaration of interest	24
Table 1.4	BPD Guideline Committee terms of reference	27
Table 2.1	Some outcomes measured in clinical trials assessing BPD treatments	36
Table 3.1	Risk factors for BPD	39
Table 4.1	DSM-IV-TR diagnostic criteria for BPD	44
Table 4.2	ICD-10 diagnostic criteria for emotionally unstable personality disorder, borderline type	44
Table 4.3	Reasons to disclose the diagnosis of BPD to the person	46
Table 4.4	Instruments for screening BPD in young people	49
Table 5.1	Effect of psychological therapies on BPD: updated literature search	52
Table 5.2	Summary of meta-analysis of psychological treatment trials in BPD	55
Table 5.3	Pharmacological treatments in people with BPD: updated literature search	59
Table 5.4	Summary of meta-analysis of pharmacotherapy trials in BPD	62
Table 5.5	Effect of BPD interventions on mental state: updated literature search	67
Table 5.6	Effect of BPD interventions on quality of life: updated literature search	70
Table 5.7	Effect of BPD interventions on suicide and self-harm: updated literature search	71
Table 5.8	Effect of BPD interventions on use of healthcare services: updated literature search	72
Table 5.9	Effect of BPD interventions on social and interpersonal functioning: updated literature search	73
Table 5.10	Delivery modes for BPD care	80
Table 5.11	Multimodal therapies versus single-mode therapies	81

List of tables (continued)

Table 5.12	BPD treatment in adolescents: updated literature search	83
Table 5.13	Treatments for co-occurring health conditions in people with BPD	86
Table 5.14	Risk factors for BPD: updated literature search	90
Table 6.1	Effectiveness and safety of BPD treatment according to type of healthcare service	93
Table 6.2	Role of acute inpatient care for BPD	96
Table 6.3	Effectiveness of long-term inpatient care for BPD	97
Table 6.4	Supporting healthcare professionals for BPD care	104
Table 7.1	Principles for collaborating with families and carers	111
Table 7.2	Priorities for carers of people with mental illness	113
Table 7.3	Checklist for health professionals caring for children of parents with a mental illness	118
Table 8.1	Principles for working with people with BPD	122
Table 8.2	Planning transitions between services and treatments	124
Table 8.3	Components of a management plan for a person with BPD	125
Table 8.4	Indicators of increased suicide risk in people with BPD	127
Table 8.5	Principles of response to a BPD crisis	131
Table 8.6	What to do if a person with BPD is at high acute risk of suicide	132

List of figures

Figure 1.1	Process used by the committee to synthesise evidence and formulate guideline recommendations	32
Figure 8.1	Estimating probable level of suicide risk based on self-harm behaviour	128

Abbreviations

A&E	accident and emergency
AGREE	Appraisal of Guidelines for Research and Evaluation instrument
BPD	borderline personality disorder
CAT	cognitive analytical therapy (a form of structured psychological therapy)
CBR	consensus-based recommendation
CBT	cognitive-behavioural therapy
CGI-BPD	Clinical Global Impression – Borderline Personality Disorder
DBT	dialectical behaviour therapy
DDP	dynamic deconstructive psychotherapy
DSM	Diagnostic and statistical manual of mental disorders
DSM-III	Diagnostic and statistical manual of mental disorders 3rd edition
DSM-IV-TR	Diagnostic and statistical manual of mental disorders 4th edition – text revision
EBR	evidence-based recommendation
ERT	emotion regulation training
EQ-5D	the EurQol Group instrument for assessing quality-of-life
EurQOL	EQ-5D (the EurQol Group quality-of-life assessment instrument)
GPM	general psychiatric management (a form of structured psychological therapy)
GSI	global severity index
ICD	International statistical classification of diseases
ICD-10	International statistical classification of diseases 10th revision
MACT	manual-assisted cognitive therapy
MAOI	monoamine oxidase inhibitor (a type of antidepressant medicine)
MBT	mentalisation-based therapy
MOTR	motive-oriented therapeutic relationship
NHMRC	National Health and Medical Research Council
PTSD	Post-traumatic stress disorder
QOL	quality of life
SCID-II	Structured clinical interview for DSM-IV axis II disorders
SCL-90	Symptom Checklist-90
SCL-90-R	Symptom Checklist-90-Revised
SFP	schema-focussed psychotherapy
SSRI	selective serotonin reuptake inhibitor
STAXI	State-trait anger expression inventory
Std diff	standard difference
STEPPS	systems training for emotional predictability and problem solving
TAU	treatment as usual
TFP	transference-focussed psychotherapy
WHOQOL-Bref	World Health Organization quality of life assessment instrument (abbreviated version)
ZAN-BPD	Zanarini rating scale for Borderline Personality Disorder

Special terms used in this document

Acute mental health services	Healthcare services that provide specialist psychiatric care for people who have severe, recent-onset (or recently worsening) symptoms of mental illness. Treatment is focussed on reducing symptoms, with a reasonable expectation of substantial improvement. In general, acute services provide relatively short-term treatment.
ADAPTE	A method for adapting an existing clinical guideline to produce a new clinical guideline (e.g. to update or improve local relevance)
Atypical antipsychotic medicines	(Also called 'second-generation' antipsychotic medicines) A group of medicines used to treat psychotic mental illnesses, such as schizophrenia, and which generally have fewer unwanted effects on the brain and nerves than the older 'typical' or 'conventional' antipsychotics. Examples of atypical antipsychotic medicines include amisulpride, aripiprazole, olanzapine, quetiapine, risperidone and ziprasidone.
Axis I disorders	The group of mental illnesses that includes all except personality disorders and mental retardation (one of five groups within the framework for assessment and diagnosis used by the American Psychiatric Association <i>Diagnostic and statistical manual of mental disorders</i>)
Axis II disorders	Personality disorders and mental retardation (one of five groups within the framework for assessment and diagnosis used by the American Psychiatric Association <i>Diagnostic and statistical manual of mental disorders</i>)
Carer	A person who provides personal care, support and assistance to another person who needs it due to a mental illness, disability, medical condition or old age. In this guideline, a carer is not a person who provides the service for payment under a contract, or voluntarily through a charitable, welfare or community organisation or as part of training. An individual is not necessarily a carer merely because he or she is a spouse or relative of the person who needs care. ^a
Cognitive-behavioural therapy	A type of psychological therapy

^a Definition adapted from Commonwealth of Australia Carer Recognition Act (2010) Available from: http://www.comlaw.gov.au/Details/C2010A00123/Html/Text#_Toc276377311.

Conventional antipsychotic medicines	(Also called 'typical' or 'first-generation' antipsychotic medicines.) A group of medicines developed in the 1950s to treat psychotic mental illnesses such as schizophrenia. Examples include haloperidol and chlorpromazine.
Comorbid condition ^b	(Classical definition.) A health condition that exists simultaneously with another condition in the same patient, but is independent of it ^c
Dialectical behaviour therapy	A type of psychological therapy
Dissociation	The experience of disruption to normal consciousness or psychological functioning, e.g. when a person feels temporarily separated from their own emotions, body or surroundings
Dual-focussed schema therapy	A type of psychological therapy
Dynamic deconstructive psychotherapy	A type of psychological therapy
Eating disorders	The group of mental illnesses that includes anorexia nervosa and bulimia nervosa
Effectiveness	The extent to which an intervention (treatment) achieves the desired therapeutic result when provided under the usual circumstances of healthcare practice
Efficacy	The extent to which an intervention (treatment) achieves the desired therapeutic result under ideal circumstances, such as a controlled clinical trial
Emotion Regulation Training	A type of psychological therapy
General Psychiatric Management	A type of psychological therapy
Health professional	Any person who provides health care or related services (excluding administrative staff), such as Aboriginal health workers, medical doctors, midwives, nurses, occupational therapists, psychiatrists, psychologists, social workers and specialists
Main clinician	The health professional (e.g. GP, psychiatrist or psychologist, therapist or case manager) who is the person's designated main point of contact and takes responsibility for coordinating the care provided by other services ^d
Manual-assisted therapies	Interventions that are performed according to specific guidelines for administration, maximising the probability of therapy being conducted consistently across settings, therapists, and clients

^b For a person with BPD who also has another mental illness, it may not be possible to identify accurately whether both conditions are causally related, given current knowledge of the aetiology of BPD. This guideline uses the term 'co-occurring' where the relationship between conditions cannot be ascertained.

^c In common usage, the term 'comorbid' is often used to refer to any health condition that exists simultaneously with another condition in the same patient, where both conditions may or may not be related.

^d Definition adapted from American Psychological Association. APA dictionary of psychology. Washington, DC: American Psychological Association; 2006.

Mentalisation-based therapy	A type of psychological therapy
Mental health services	Healthcare services that have the main function of providing clinical treatment, rehabilitation or community support for people with mental illness or psychiatric disability, and/or their families and carers. Mental health services include organisations operating in both the government and non-government sectors.
Mental illness	A clinically diagnosable disorder that significantly interferes with an individual's cognitive, emotional or social abilities. The diagnosis of mental illness is generally made according to the classification systems of the <i>Diagnostic and statistical manual of mental disorders</i> (DSM) or the <i>International statistical classification of diseases and related health problems</i> (ICD).
Mood disorders	A group of mental illnesses that affect a person's ability to control emotions (e.g. depression, bipolar disorder)
Multimodal therapy	Any treatment approach that uses more than one way of delivering the treatment to the person (e.g. a psychological treatment plus a medicine, or face-to-face psychotherapy plus group psychoeducation sessions)
Pharmacotherapy	(Also called pharmacological treatment, pharmacological therapy or drug treatment). The use of medicines to treat a health disorder.
Primary care services	Community-based healthcare services that are usually the first point of contact for people experiencing a mental health problem or a mental illness and their families. The primary care sector includes general practitioners (GPs), emergency departments and community health centres.
Private sector specialist mental health services	The range of mental health care and services provided by psychiatrists, mental health nurses and allied mental health professionals in private practice. Private mental health services also include inpatient and day only services provided by privately managed hospitals, for which private health insurers pay benefits, and some services provided in general hospital settings.
Psychoanalytic therapy (psychoanalysis)	A type of psychological therapy
Psychodynamic therapy	A type of psychological therapy
Psychological therapy/treatment	The range of treatments that are based on talking and thinking. Psychological treatments are used for a range of mental health problems and mental illnesses. Psychological treatments help by giving people an opportunity to talk to a specially trained health professional in order to understand their symptoms, and to help them adapt how they feel, think and act in response to symptoms. ^e

^e Definition adapted from SANE Australia. Psychological treatments [factsheet] (available at www.sane.org/information/factsheets-podcasts/549-psychological-treatments)

Psychosis	The general name for a group of mental illnesses that are mainly characterised by symptoms like delusions and hallucinations or signs like disorganised speech or behaviour. When someone experiences psychosis they are unable to distinguish what is real from what is not real. Most people can recover from an episode of psychosis. ^f
Psychosocial therapy/treatments	The range of treatments that include structured psychological therapies, psychoeducation, self-help groups and training that aims to improve ability to work and improve social life
Psychotherapy	A type of psychological therapy (broad term for a range of therapies)
Schema-focussed psychotherapy	A type of psychological therapy
Selective serotonin reuptake inhibitors	A group of medicines used to treat depression
Specialised BPD service	A healthcare service that comprises a multidisciplinary team specialising primarily in the treatment of people with BPD
Structured psychological therapy	A psychological therapy that is designed based on a specific set of ideas and a theory about the condition being treated, is focussed on achieving change, is provided by specially trained health professionals in a consistent way, and is given as a series of sessions over the planned course of treatment (see Psychological therapy).
Transference-focussed therapy	A type of psychological therapy
Stepped care	An approach to healthcare that involves beginning with the least intensive treatment that is likely to be effective for an individual, and providing more intensive treatment (e.g. a hospital stay or specialist treatment) if the person needs it
STEPPS	(Systems training for emotional predictability and problem solving) – a type of psychological therapy.

^f Definition adapted from SANE Australia. Psychological treatments [factsheet] (available at www.sane.org/information/factsheets-podcasts/549-psychological-treatments)

Summary

About borderline personality disorder

Borderline personality disorder (BPD) is a mental illness that can make it difficult for people to feel safe in their relationships with other people, to have healthy thoughts and beliefs about themselves, and to control their emotions and impulses. People with BPD may experience distress in their work, family and social life, and may harm themselves. Having BPD is not the person's own fault – it is a condition of the brain and mind.

Research has not yet discovered exactly how a person develops BPD, but it probably involves a combination of biological factors (such as genetics) and experiences that happen to a person while growing up (such as trauma early in life). For most people with BPD, symptoms begin during adolescence or as a young adult, but tend to improve during adult life. Research has not yet shown how health systems can best help prevent people developing BPD.

Making the diagnosis of BPD

Signs that someone has BPD include making frantic efforts to avoid being abandoned by other people (even if they are only imagining that other people are abandoning them), repeatedly having intense and unstable relationships with other people (such as intensely disliking someone that they previously idealised), being very unsure of who they are and what to think about themselves, acting impulsively in ways that could be very risky (such as spending money, risky sexual behaviour, substance abuse, reckless driving or binge eating), repeatedly harming themselves or threatening to commit suicide, experiencing intense emotional 'lows', irritability or anxiety for a few hours or days at a time, constantly feeling 'empty', experiencing unusually intense anger and being unable to control it, and sometimes feeling paranoid or experiencing strange feelings of being detached from their own emotional or physical situation.

Before making the diagnosis of BPD, trained mental health professionals should carefully ask questions about the person's life, experiences and symptoms. Generally, health professionals should not give prepubescent children a diagnosis of BPD.

After making the diagnosis, health professionals should tell people with BPD that they have this illness, explain the symptoms, talk about how the person's own experience would fit this diagnosis, emphasise that it is not their fault, and carefully explain that effective treatments are available. Some health professionals believe it is better not to tell a person they have BPD (particularly if the person is younger than 18 years old), mainly because some parts of the health system and society have discriminated against people with BPD and increased their suffering. However, telling the person the diagnosis can help them understand what they have been experiencing and might help ensure they receive effective treatment.

Treatments for BPD

For many people with BPD, their goals for treatment involve managing their emotions, finding purpose in life, and building better relationships. Many people with BPD have experienced significant trauma, either in the past or in their daily lives, so they need health care that makes them feel safe while they recover.

Psychological treatment

People with BPD should be provided with structured psychological therapies that are specifically designed for BPD, and conducted by one or more health professionals who are adequately trained and supervised. There is evidence that structured psychological therapies for BPD are more effective than the care that would otherwise be available.

Health professionals should advise people with BPD which structured psychological therapies are available, explain what these treatments involve, and offer them a choice if more than one suitable option is available.

Adolescents (14–18 years) with BPD, or who have symptoms of BPD that are significantly affecting their lives, should be offered structured psychological therapies that are specifically designed for BPD and provided for a planned period of time. Where available and appropriate, adolescents and people under 25 years should be provided with treatment in youth-oriented services.

Medicines

Doctors should not choose medicines as a person's main treatment for BPD, because medicines can only make small improvements in some of the symptoms of BPD, but do not improve BPD itself.

Hospitals and specialised BPD services

Admissions to hospitals or other inpatient facilities should not be used as a standard treatment for BPD and should generally only be used as short-term stays to deal with a crisis when someone with BPD is at risk of suicide or serious self-harm. Hospital stays should be short, and aim to achieve specific goals that the person and their doctors have agreed on. Health professionals should generally not arrange long-term hospital stays for people with BPD.

If a person with BPD needs to visit an emergency department because they have harmed themselves or cannot cope with their feelings, staff should arrange mental health treatment to begin while the person's medical needs are being dealt with. Emergency department staff should attend to self-inflicted injuries professionally and compassionately.

Where available, health professionals should consider referring people with severe and/or enduring BPD to a specialised BPD service (e.g. Spectrum Personality Disorder Service for Victoria) for assessment and ongoing care.

Making our health system work better for people with BPD

Health professionals at all levels of the healthcare system and within each type of health service, including general practices and emergency departments, should recognise that BPD treatment is a legitimate use of healthcare services. Having BPD should never be used as a reason to refuse health care to a person.

If more than one health service is involved in an individual's care, all the health professionals and services should choose one health professional to be the person's main contact person, who will be responsible for coordinating the person's care across all health services that they use.

For all people with BPD, a tailored management plan should be developed in collaboration with them. The person's family, partner or carer should be involved in developing the management plan, if this is in the person's interests and they have given consent for others to be involved. The management plan (including a clear, short crisis plan) should be shared with all health professionals involved in their care, and should be updated from time to time. If a person with BPD repeatedly visits the emergency department or their GP for immediate help during a crisis, the crisis plan should be made available to these health professionals too.

People who are responsible for planning or managing health services that provide care for people with BPD should make sure the health professionals who work there get proper training in how to care for people with BPD, and adequate supervision according to their level of experience and the type of work they are doing. Health system planners and managers should also make sure health professionals are given enough support and have access to help from experts who are experienced in caring for people with BPD.

Supporting families, partners and carers of people with BPD

Families, partners and carers can play an important role in supporting the person's recovery. Health professionals should acknowledge and respect their contribution. Health professionals should, with the person's consent, involve families, partners and carers of people with BPD when developing a crisis plan. However, some people with BPD prefer not to involve others. Health professionals should respect their choice, and offer them a chance to change their mind later.

Health professionals should help families, partners and carers of people with BPD by giving them clear, reliable information about BPD, arranging contact with any support services that are available (such as carer-led programs that educate families/carers on BPD and respite services) giving them information about how to deal with suicide attempts or self-harm behaviour, advising them about the most helpful ways to interact with the person with BPD, and offering referral to family counselling.

Having BPD does not mean a person cannot be a good parent. Health professionals may consider referring parents with BPD to programs designed to help them improve parenting skills. If a mother has BPD, health professionals who provide care for her should do everything possible to help her children too. If a mother with BPD needs to go to hospital, her baby should stay with her if possible.

Where children or young people are carers of an adult with BPD, health professionals should provide education about BPD, help them deal with their parent's emotional and psychological states, and put them in touch with services that can help them with their own life.

General principles of BPD care for all health professionals

Health professionals working with people who have BPD should be respectful, caring, compassionate, consistent and reliable. They should listen and pay attention when the person is talking about their experiences, take the person's feelings seriously, and communicate clearly. If a person with BPD is upset or letting their feelings take over, health professionals should stay calm, and keep showing a non-judgemental attitude.

Health professionals should understand that people with BPD may be very sensitive to feeling rejected or abandoned, and so may be upset when their treatment comes to an end or if they can no longer see the same staff. Health professionals should plan these changes in advance and explain them to the person.

If people with BPD repeatedly self-harm or attempt suicide, their usual health professional should assess their risk regularly. Health professionals need to gain an understanding of the person over time to be able to tell when the person is at high risk of suicide, and to know whether the person needs to keep working on their long-term BPD treatment or whether they need immediate special care to keep them safe. People who live with thoughts of suicide over time tend to recover when their quality of life improves.

When a person with BPD is experiencing a crisis, health professionals should focus on the 'here and now' matters. Issues that need more in-depth discussion (e.g. past experiences or relationship problems) can be dealt with more effectively in longer-term treatment by the health professional who treats them for BPD (e.g. the person's usual psychiatrist).

Health professionals should try to make sure the person stays involved in finding solutions to their own problems, even during a crisis.

Executive Summary

About the recommendations

This guideline includes evidence-based recommendations (EBR), consensus-based recommendations (CBR) and practice points (PP) as defined in Table i. Recommendations and practice points were developed by the BPD Guideline Development Committee ('the Committee'), a multidisciplinary committee of clinical, research, consumer and carer representatives. When formulating the recommendations, the Committee considered both the findings and recommendations of the United Kingdom (UK) national BPD clinical practice guideline (*Borderline personality disorder: treatment and management. National clinical practice guideline number 78*),¹ and the findings of a new systematic evidence review undertaken for this guideline.

For each EBR, supporting references are listed and the grade (Table ii) is indicated according to National Health and Medical Research Council (NHMRC) *Levels of evidence and grades for recommendations for developers of guidelines*.² The grade indicates the strength of the recommendation in consideration of the strength of evidence, consistency of evidence across studies, the likely clinical impact, and the degree to which the study findings can be generalised and applied in the Australian context.

The clinical questions on which the recommendations are based are listed in Chapter 11.

The process followed by the Committee when developing recommendations is summarised in Section 1.7 and described in detail in Appendix B.3.

Details of the process followed by the Committee when assigning grades for recommendations are shown in Appendix B.3.

Table i Definitions of types of recommendations

Abbreviation	Type of recommendation
EBR	<i>Evidence-based recommendation</i> – a recommendation formulated after a systematic review of the evidence, indicating supporting references
CBR	<i>Consensus-based recommendation</i> – a recommendation formulated in the absence of quality evidence, after a systematic review of the evidence was conducted and failed to identify admissible evidence on the clinical question
PP	<i>Practice point</i> – a recommendation on a subject that is outside the scope of the search strategy for the systematic evidence review, based on expert opinion and formulated by a consensus process

Table ii. Definition of grades for evidence-based recommendations

Grade	Description
A	Body of evidence can be trusted to guide practice
B	Body of evidence can be trusted to guide practice in most situations
C	Body of evidence provides some support for recommendation(s) but care should be taken in its application
D	Body of evidence is weak and recommendation must be applied with caution

Key recommendations

Recommendation		Type and grade (if applicable)	Section	Page	Clinical question
38.	Health professionals at all levels of the healthcare system and within each type of service setting should: • acknowledge that BPD treatment is a legitimate use of healthcare services • be able to recognise BPD presentations • be aware of general principles of care for people with BPD and specific effective BPD treatments • provide appropriate care (including non-specific mental health management, specific treatments for BPD and treatment for co-occurring mental illness) according to their level of training and skill • refer the person to a specialised BPD service or other services as indicated • undertake continuing professional development to maintain and enhance their skills.	CBR	6.6.3	101	20
8.	People with BPD should be provided with structured psychological therapies that are specifically designed for BPD, and conducted by one or more adequately trained and supervised health professionals.	EBR (B) ^{1, 3-40}	5.1.3	58	7 and 8
11.	Medicines should not be used as primary therapy for BPD, because they have only modest and inconsistent effects, and do not change the nature and course of the disorder.	EBR (B) ^{1, 31, 37, 41-74}	5.2.3	65	9
31.	The majority of a person's treatment for BPD should be provided by community-based mental health services (public and private).	CBR	6.1.3	95	15

Recommendation		Type and grade (if applicable)	Section	Page	Clinical question
23.	Adolescents with BPD should be referred to structured psychological therapies that are specifically designed for this age group. Where unavailable they should be referred to youth mental health services.	PP	5.7.3	85	5
10.	Health professionals should inform people with BPD about the range of BPD-specific structured psychological therapies that are available and, if more than one suitable option is available, offer the person a choice.	CBR	5.1.3	58	7 and 8
51.	Health professionals should refer families, partners and carers of people with BPD to support services and/or psychoeducation programs on BPD, where available.	CBR	7.2.3	112	26
1. 4.	Health professionals should consider assessment for BPD (or referral for psychiatric assessment) for people (including those aged 12–18 years) with any of the following: • frequent suicidal or self-harming behaviour • marked emotional instability • multiple co-occurring psychiatric conditions • non-response to established treatments for current psychiatric symptoms • a high level of functional impairment.	PP (adults) CBR (adolescents)	4.1.4 4.2.3	46 48	N/A 1

Full list of recommendations

Recommendation	Type and grade (if applicable)	Section	Page	Clinical question
Identifying and assessing BPD				
1. Health professionals should consider assessment for BPD (or referral for psychiatric assessment) for a person with any of the following: • frequent suicidal or self-harming behaviour • marked emotional instability • multiple co-occurring psychiatric conditions • non-response to established treatments for current psychiatric symptoms • a high level of functional impairment.	PP	4.1.4	46	N/A
2. Once the diagnosis is established, it should be disclosed and explained to the person, emphasising that effective treatment is available.	PP	4.1.4	46	N/A
3. If the person agrees, the diagnosis should be explained to the person's family, partner or carers at a time that both the clinician and the person think appropriate.	PP	4.1.4	46	N/A
4. Health professionals should consider an assessment for BPD in people aged 12–18 years with any of the following: • frequent suicidal or self-harming behaviour • marked emotional instability • multiple co-occurring psychiatric conditions • non-response to established treatments for current psychiatric symptoms • a high level of functional impairment.	CBR	4.2.3	48	1
5. After appropriate assessment, health professionals should make the diagnosis of BPD in a person aged 12–18 years who meets the diagnostic criteria. The diagnostic criteria for BPD should not generally be applied to prepubescent children.	CBR	4.2.3	48	1

Recommendation		Type and grade (if applicable)	Section	Page	Clinical question
6.	A thorough clinical interview should be used to diagnose BPD in young people. This can be assisted by the use of a validated semi-structured instrument.	CBR	4.3.3	49	2
7.	Validated BPD screening tools can be used with young people attending mental health services to identify individuals in need of further diagnostic assessment for BPD.	CBR	4.3.3	49	2
Managing BPD					
8.	People with BPD should be provided with structured psychological therapies that are specifically designed for BPD, and conducted by one or more adequately trained and supervised health professionals.	EBR (B) ^{1, 3-40}	5.1.3	58	7 and 8
9.	When planning structured psychological therapies for BPD, the therapist should adapt the frequency of sessions to the person's needs and circumstances, and should generally consider providing at least one session per week.	CBR	5.1.3	58	7 and 8
10.	Health professionals should inform people with BPD about the range of BPD-specific structured psychological therapies that are available and, if more than one suitable option is available, offer the person a choice.	CBR	5.1.3	58	7 and 8
11.	Medicines should not be used as primary therapy for BPD, because they have only modest and inconsistent effects, and do not change the nature and course of the disorder.	EBR (B) ^{1, 31, 37, 41-74}	5.2.3	65	9
12.	The time-limited use of medicines can be considered as an adjunct to psychological therapy, to manage specific symptoms.	CBR	5.2.3	65	9
13.	Caution should be used if prescribing medicines that may be lethal in overdose, because of high suicide risk with prescribed medicines among people with BPD.	PP	5.2.3	65	9
14.	Caution should be used if prescribing medicines associated with substance dependence.	PP	5.2.3	65	9

Recommendation		Type and grade (if applicable)	Section	Page	Clinical question
15.	Before starting time-limited pharmacotherapy for people with BPD: • ensure that a medicine is not used in place of other, more appropriate interventions • take account of the psychological role of prescribing (both for the individual and for the prescriber) and the impact that prescribing decisions may have on the therapeutic relationship and the overall BPD management plan, including long-term treatment strategies • use a single medicine and avoid polypharmacy, if possible • ensure that there is consensus among prescribers about the medicine used, and collaboration with other health professionals involved in the person's care, and that the main prescriber is identified • establish likely risks of prescribing, including interactions with alcohol and other substances.	PP	5.2.3	65	9
16.	The use of medicines can be considered in acute crisis situations where psychological approaches are not sufficient.	PP	5.2.3	65	9
17.	If medicines have been prescribed to manage a crisis, they should be withdrawn once the crisis is resolved.	PP	5.2.3	65	9
18.	When reduction in self-harm is a treatment goal for women with BPD, offer a comprehensive* dialectical behaviour therapy program. *standardised, manual-based therapy using the method developed by its originators	EBR (B) ^{12, 13, 15, 19, 75}	5.3.3	79	6
19.	When reduction in anger, anxiety or depression is a treatment goal for women with BPD, offer a comprehensive* dialectical behaviour therapy program. *standardised, manual-based therapy using the method developed by its originators	EBR (B) ^{12, 13, 15, 19, 75}	5.3.3	79	6
20.	Pharmacotherapy should not be routinely added to psychological interventions in the treatment of BPD.	EBR (D) ^{30, 31, 50, 58}	5.6.3	82	10

Recommendation		Type and grade (if applicable)	Section	Page	Clinical question
21.	In addition to one-to-one psychological therapies, consider offering psychoeducation, family therapy and/or group sessions, as appropriate to the person's needs.	CBR	5.6.3	82	10
22.	People aged 14–18 years with BPD or clinically significant features of BPD should be offered time-limited structured psychological therapies that are specifically designed for BPD.	EBR (B) ^{29, 76}	5.7.3	85	5
23.	Adolescents with BPD should be referred to structured psychological therapies that are specifically designed for this age group. Where unavailable they should be referred to youth mental health services.	PP	5.7.3	85	5
24.	When planning treatment for people under 18 years with BPD or clinically significant features of BPD, consider the person's developmental stage and living circumstances, and involve their family in care as appropriate.	PP	5.7.3	85	5
25.	For adolescents younger than 14 years with features of BPD, offer clinical psychological support and monitoring, involving their families.	PP	5.7.3	85	5
26.	For people with BPD who have a co-occurring mental illness (e.g. a substance use disorder, mood disorder or eating disorder), both conditions should be managed concurrently.	CBR	5.8.3	88	11 and 13
27.	Interventions for BPD and co-occurring mental illness should be integrated, where possible. If possible, the same therapist or treatment team should provide treatment for both conditions. Where this is not possible, the health service or therapist providing treatment for the co-occurring condition should collaborate with the person's main clinician who is responsible for managing their BPD.	CBR	5.8.3	88	11 and 13

Recommendation		Type and grade (if applicable)	Section	Page	Clinical question
28.	If a person's substance use is severe, life-threatening or interfering with BPD therapy, health professionals should actively work to engage the person in effective BPD treatment, but give priority in the first instance to the stabilisation of their substance use disorder to allow effective BPD treatment. Treatment should focus on managing the substance use disorder before effective BPD treatment can continue.	CBR	5.8.3	88	11 and 13
29.	Medical symptoms in people with BPD should be thoroughly assessed and managed effectively by a GP or appropriate specialist.	CBR	5.8.3	88	11 and 13
30.	GPs should provide advice and follow-up (e.g. reminders) to encourage people with BPD to participate in screening and preventive health measures, such as cervical cancer screening for women.	PP	5.8.3	88	11 and 13
Organising healthcare services to meet the needs of people with BPD					
31.	The majority of a person's treatment for BPD should be provided by community-based mental health services (public and private).	CBR	6.1.3	95	15
32.	BPD treatments should be offered through a range of services, as appropriate to the individual's current clinical presentation, course of illness, needs and (if applicable) preferences.	CBR	6.1.3	95	15
33.	Acute inpatient admission to provide structured crisis intervention could be considered for the treatment of people who are suicidal or have significant co-occurring mental health conditions.	EBR (C) ⁷⁷	6.3.3	96	16
34.	Inpatient care should be reserved for short-term crisis intervention for people at high risk of suicide or medically serious self-harm. Where used, inpatient care should be: • brief (except for specialised structured residential services that provide intensive interventions) • directed towards specific, pre-identified goals.	CBR	6.3.3	96	16

Recommendation		Type and grade (if applicable)	Section	Page	Clinical question
35.	Long-term inpatient care for people with BPD should generally be avoided, except in the context of specialised BPD services.	CBR	6.4.3	98	18
36.	When considering inpatient care for a person with BPD, health professionals should involve the person (and family or carers, if possible) in the decision, and ensure the decision is based on an explicit, joint understanding of the potential benefits and likely harm that may result from admission, and agree on the length and purpose of the admission in advance.	PP	6.4.3	98	18
37.	Health professionals should consider referring people with severe and/or enduring BPD to a suitable specialised BPD service (where available) for assessment and ongoing care, if appropriate.	CBR	6.5.3	99	17
38.	Health professionals at all levels of the healthcare system and within each type of service setting should: • acknowledge that BPD treatment is a legitimate use of healthcare services • be able to recognise BPD presentations • be aware of general principles of care for people with BPD and specific effective BPD treatments • provide appropriate care (including non-specific mental health management, specific treatments for BPD and treatment for co-occurring mental illness) according to their level of training and skill • refer the person to a specialised BPD service or other services as indicated • undertake continuing professional development to maintain and enhance their skills.	CBR	6.6.3	101	20
39.	Clinicians treating people with BPD should follow a stepped-care approach in which an individual's usual care is based on the least intensive treatment (such as general practice care and regular contact with a community mental health service), and referral to more intensive treatment (such as crisis intervention, a specialised BPD service, or specialised BPD programs) is provided when indicated.	CBR	6.7.3	103	21

Recommendation		Type and grade (if applicable)	Section	Page	Clinical question
40.	Health professionals within each type of service should set up links with other services to facilitate referral and collaboration.	CBR	6.7.3	103	21
41.	Managers and health system planners should configure services to ensure that people can access more intensive treatment options, such as a specialised BPD service, when needed.	CBR	6.7.3	103	21
42.	If more than one service is involved in an individual's care, services should agree on one provider as the person's main contact (main clinician), who is responsible for coordinating care across services.	CBR	6.7.3	103	21
43.	All health professionals treating people with BPD should make sure they know who the person's main clinician is.	CBR	6.7.3	103	21
44.	Health system planners should ensure that people have access to healthcare services appropriate to their needs within their local area or as close as possible.	CBR	6.7.3	103	21
45.	Where more than one treatment option or service setting is suitable for an individual's clinical needs, health professionals should explain the options and support the person to choose.	CBR	6.7.3	103	21
46.	Those responsible for planning or managing services that provide care for people with BPD should ensure that health professionals receive training in BPD management.	CBR	6.8.3	105	22
47.	For group practices or services with several health professionals, training should involve all staff within a service, using a group learning approach.	CBR	6.8.3	105	22
48.	Service managers should ensure that caseloads for clinicians who treat people with BPD are appropriate and realistic according to: • their experience • the needs of individuals according to phase of treatment • the requirements of the specific treatments provided • the number of complex cases.	CBR	6.8.3	105	22

Recommendation		Type and grade (if applicable)	Section	Page	Clinical question
49.	Those responsible for planning or managing services that provide care for people with BPD should ensure that health professionals receive adequate supervision according to their level of experience and BPD caseload (taking into account case complexity).	CBR	6.8.3	105	22
50.	Those responsible for planning or managing services that provide care for people with BPD should ensure that health professionals receive appropriate support, including: • participation in a structured peer support program • access to secondary consultation provided by an expert in BPD care or specialised BPD service.	CBR	6.8.3	105	22
Supporting families and carers					
51.	Health professionals should refer families, partners and carers of people with BPD to support services and/or psychoeducation programs on BPD, where available.	CBR	7.2.3	112	26
52.	Health professionals should provide families, partners and carers of people with BPD with information about BPD or direct them to sources of reliable information.	CBR	7.2.3	112	26
53.	Health professionals should include families, partners and carers of people with BPD when developing crisis plans, if possible and with the person's consent.	CBR	7.2.3	112	26
54.	Health professionals should provide families, partners and carers of people with BPD with information about dealing with suicide attempts or self-harm behaviour.	CBR	7.2.3	112	26

Recommendation		Type and grade (if applicable)	Section	Page	Clinical question
55.	Health professionals should advise families, partners and carers of people with BPD about helpful ways of interacting with the person who has BPD, including: • showing empathy and a non-judgemental attitude • encouraging the person to be independent by allowing and supporting them to make their own decisions, but intervening for their safety when necessary • listening to the person with BPD when they express their problems and worries.	CBR	7.2.3	112	26
56.	When discussing childhood trauma, including sexual abuse, with the family of a person with BPD, health professionals should manage these discussions in a manner that minimises guilt, stigma and blame. Such discussions should occur with the consent of the person with BPD, (taking into account child protection legislation if the person is a minor).	CBR	7.2.3	112	26
57.	Health professionals caring for parents with BPD should consider the needs of children and arrange assessment of their mental health and welfare needs if necessary.	PP	7.3.3	115	23
58.	Health professionals assessing a person with BPD (particularly during a crisis) should determine whether the person has dependent children and ensure that they are properly cared for (e.g. refer to a social worker).	PP	7.3.3	115	23
59.	Health professionals can support families, partners and carers by referring or directing them to: • general family counselling and psychoeducation with a focus on BPD • structured family programs specific to BPD • peer support programs such as carer-led programs that educate families/carers on BPD • respite services.	CBR	7.4.3	120	24
60.	If a mother with BPD requires hospital admission, separation from her infant should be avoided if possible.	PP	7.4.3	120	24

Recommendation		Type and grade (if applicable)	Section	Page	Clinical question
61.	Health professionals involved in the assessment of parenting capacity should advise authorities that a parent's BPD alone is not sufficient reason for removing a child from the parent's care.	PP	7.4.3	120	24
62.	People with BPD who have infants or young children should be provided with interventions designed to support parenting skills and attachment relationships.	PP	7.4.3	120	24
63.	Where children are carers of an adult with BPD, specific support should be provided, including: • education about the parent's mental illness • strategies for management of adult's emotional and psychological states • strategies for helping them with peer relationships and social functioning • psychological and emotional support • referral to services for young people who are carers • respite services.	PP	7.4.3	120	24

1. Introduction

1.1 Purpose of this guideline

The purposes of this guideline are to:

- improve the diagnosis of BPD
- improve the care of people with BPD, and to relieve their distress and suffering
- provide a summary of current evidence for the effectiveness and efficacy of treatments for BPD
- guide health professionals in the care of people with BPD or features of BPD within Australian healthcare services, by providing evidence-based recommendations and, where there is insufficient evidence, providing recommendations based on consensus
- help health professionals support the families and carers of people with BPD
- provide guidance on the organisation of healthcare services.

1.2 Intended users of this guideline

This guideline is intended for health professionals, including:

- Aboriginal health workers
- clinical psychologists
- general practitioners
- mental health nurses
- mental health occupational therapists
- mental health social workers
- midwives
- nurses
- psychiatrists
- psychologists
- other health professionals who care for people with BPD and those who may treat other medical conditions in people with BPD, including specialists and staff of emergency services.

The recommendations in this guideline are not intended for those with non-clinical roles who may encounter people with BPD outside the health system, such as police, teachers, volunteers or those involved in social organisations.

1.3 Target population

This guideline includes recommendations for the care of:

- adolescents (aged 12–18 years) and adults (aged over 18 years) with a diagnosis of BPD
- adolescents and adults who show features of BPD
- individuals with BPD who have a co-occurring mental health condition.

1.4 Healthcare settings to which this guideline applies

This guideline provides recommendations for the care of adults with a diagnosis of BPD using Australian health services including:

- general practices
- community health centres
- public and private hospitals
- community mental health services (child and adolescent/youth services, adult services)
- private office-based mental health practices
- health services within the criminal justice system
- specialised personality disorder treatment services.

In addition, this guideline provides recommendations for the organisation and delivery of services for people with BPD.

1.5 Background

This section provides an overview of current approaches to understanding and managing BPD. This information is not intended as clinical guidance, but is provided as context for the evidence and recommendations in chapters 3–7.

1.5.1 Description of BPD

Borderline personality disorder (BPD) is a common mental illness characterised by poor control of emotions and impulses, unstable interpersonal relationships and unstable self-image (see Chapter 4).^{78,79} Symptoms of BPD typically emerge during adolescence⁸⁰ and early adulthood.⁷⁹

People with BPD experience significant suffering and distress due to difficulties in relating to other people and the world around them, disruption to family and work life, and social problems. The diagnosis of BPD is associated with considerable social stigma.⁸¹

BPD is associated with severe and persistent impairment of psychosocial function, high risk for self-harm and suicide, a poor prognosis for co-existing mental health illness, and heavy use of healthcare resources.⁷⁸ International data show that the suicide rate among people with BPD is higher than that of the general population.⁸² Estimated suicide rates among people with BPD range from 3% to 10%.^{78, 82}

The prognosis for people with BPD is good over the medium to long term. A high proportion of people with BPD recover significantly and no longer meet diagnostic criteria for BPD. Among those who experience remission, only a minority relapse.⁸³⁻⁸⁷ Longitudinal studies with follow-up of 10–16 years have reported that almost all people with BPD will eventually achieve symptomatic recovery, but may still experience impaired psychosocial functioning.^{86, 88}

1.5.2 Prevalence

In other countries, the prevalence of BPD among the general population has been estimated at approximately 1–4%.⁸⁹⁻⁹⁵ The prevalence of BPD among people using psychiatric services has been estimated at up to 23% for outpatient populations⁹⁶⁻¹⁰⁰ and up to 43% for inpatient populations.¹⁰¹⁻¹⁰⁶ Among adolescents, BPD rates have been estimated at around 1% in some studies^{107, 108} but up to 14% in one study.¹⁰⁹

Few studies have assessed the prevalence of personality disorders in Australia. The prevalence of BPD among Australians aged 24–25 years has been estimated at approximately 3.5%.⁹³ Earlier research estimated that approximately 1% of Australian adults had BPD.¹¹⁰ There are no prevalence data for Australian adolescents.

1.6 The clinical need for this guideline

The care of people with BPD is very challenging for health professionals and for the health system.¹¹¹

Australians with BPD experience difficulties gaining access to effective treatment and support services.^{112, 113} In 2005, a consultation by the Mental Health Council of Australia and the Brain and Mind Research Institute, in association with the Human Rights and Equal Opportunity Commission, reported that people with BPD, carers and service providers throughout Australian mental health services expressed concern that the availability of BPD therapies is extremely limited, particularly for psychological therapies.¹¹² The urgent need for accessible, appropriate treatment for people with BPD has been acknowledged by an Australian Parliament Senate Select Committee on Mental Health and an Australian Parliament Senate Standing Committee on Community Affairs (Table 1.1).^{113, 114} These committees identified several areas in which the Australian health system must be improved to provide better care and support options for people with BPD, and reported the following findings:

- BPD is under-recognised.¹¹⁴
- Health professionals are often not aware of the most effective treatments for BPD, and these are not being offered to people who need them.¹¹⁴
- Due to lack of appropriate services, people with BPD often present to emergency departments or are admitted to secure inpatient units. These treatment settings are not therapeutic for people with BPD and can contribute to the cycle of admission, self-destructive and other maladaptive behaviours, and readmission.¹¹⁴
- Consumers and carers have commonly reported discrimination by mental health professionals against people with BPD.^{112, 113} Widespread selective denial of access to people with BPD by Australian mental health services has been documented.¹¹²
- Access to BPD services within the criminal justice system is limited, despite the relatively high rates of BPD among prison populations.^{112, 115, 116}

The Australian Parliament Senate Standing Committee on Community Affairs recommended in its 2008 report (*Towards recovery: mental health services in Australia*)¹¹⁴ that the Australian, state and territory governments, through the Council of Australian Governments (COAG), jointly fund a nationwide BPD initiative to include:

- designated BPD outpatient care units in selected trial sites in every jurisdiction, to provide assessment, therapy, teaching, research and clinical supervision
- a training program for mental health services and community-based organisations in the effective care of people with BPD
- a program targeting adolescents and young adults, aiming to improve recognition of BPD
- a program targeting providers of primary health care and mental health care, aiming to improve attitudes and behaviours toward people with BPD.

In 2010 the Australian Government identified the need for a clinical practice guideline to provide Australian health professionals with relevant and up-to-date evidence for the effectiveness of treatments for BPD.

Table 1.1 The need for improved BPD services in Australia

A diagnosis of BPD closes the door to already limited mental health services. It leads to social rejection and isolation. Sufferers are blamed for their illness, regarded as 'attention seekers' and 'trouble makers'. BPD is the diagnosis every patient wants to avoid.¹¹³

Borderline Personality Disorder seems to be as much a recipe for marginalisation as it is a diagnosis.¹¹³

...[A]ccess to services designed for people with BPD is particularly problematic. It is a chronic condition requiring integrated care and specialised services that just do not exist beyond the private sector. Adding to the service access issues is the remarkable situation that service providers and clinicians themselves marginalise and stigmatise people with borderline personality disorder. Some see people with BPD as too problematic, as attention seekers or as impossible to treat. The committee was advised that services need to be overhauled and clinicians called to account, with better awareness and training about the disorder and effective treatments.¹¹⁴

Accessible, appropriate treatments for those experiencing BPD, and an end to marginalisation of the disorder within the community and the mental health sector, are urgently needed.¹¹³

There is a clear need for a change in service response for those experiencing BPD, including the provision of treatments appropriate for this disorder.¹¹³

Importantly, given the nature of the illness and its disastrous impact on families and relationships, early intervention is a priority.¹¹⁴

Sources: Senate Select Committee on Mental health,¹¹³ and Australian Parliament Senate Standing Committee on Community Affairs¹¹⁴

1.7 Methods used to develop this guideline

National Health and Medical Research Council (NHMRC) developed this guideline in accordance with the NHMRC standard (*Procedures and requirements for meeting the 2011 NHMRC standard for clinical practice guidelines*¹¹⁷).

1.7.1 Multidisciplinary committee

In January 2011, NHMRC convened a multidisciplinary committee of clinical, consumer and carer representatives with specific expertise in BPD. Members of the BPD Guideline Development Committee (the Committee) are listed in Table 1.2.

The process for the Committee's appointment is described in Appendix A.2. Committee members' declarations of interest are listed in Table 1.3.

The Committee's terms of reference are shown in Table 1.4.

Table 1.2 Committee membership

	Titles and affiliations	Role on committee
Dr Michael Smith	Clinical Director, Australian Commission on Safety and Quality in Health Care New South Wales	Chair
Associate Professor Andrew Chanen	Orygen Youth Health Research Centre, Centre for Youth Mental Health, The University of Melbourne Acting Director of Clinical Services, Orygen Youth Health Victoria	Psychiatrist
Mr Fred Ford	Carer Representative, Mental Health Council of Australia New South Wales	Carer
Professor Brin Grenyer	Scientific Director, Neuroscience and Mental Health, Illawarra Health and Medical Research Institute Professor of Psychology, University of Wollongong New South Wales	Clinical psychologist
Professor Jane Gunn	Chair, Primary Care Research, University of Melbourne Head, Department of General Practice, General Practice and Primary Health Care Academic Centre, Melbourne Medical School, University of Melbourne Victoria	General practitioner
Professor Mike Hazelton	Head, School of Nursing and Midwifery, The University of Newcastle Fellow, Australian College of Mental Health Nurses New South Wales	Nurse
Dr Anthony Korner	Senior Lecturer, University of Sydney Acting Director, Westmead Psychotherapy Program Senior Staff Specialist, Sydney West Area Health Network New South Wales	Psychiatrist
Ms Janne McMahon	Chair and Executive Officer, Private Mental Health Consumer Carer Network (Australia) South Australia	Consumer
Professor Louise Newman, AM	Director, Monash University Centre for Developmental Psychiatry and Psychology Professor of Developmental Psychiatry, Monash University Victoria	Child psychiatrist
Dr Sathya Rao	Clinical Director and Consultant Psychiatrist, Spectrum, The Personality Disorder Service for Victoria Victoria	Psychiatrist
Ms Teresa Stevenson	Specialist Clinical Psychologist Discipline Coordinator of Psychology and Team Leader, Early Episode Psychosis Program, Peel and Rockingham Kwinana Mental Health Services Western Australia	Clinical psychologist

Table 1.2 (cont.)

	Titles and affiliations
Technical team	
Associate Professor Nicole Lee	Methodologist, LeeJenn Health Consultants
Ms Jenni Harman	Medical writer, Meducation
Dr Sue Phillips (until December 2011)	Director, Research Implementation Program, NHMRC
Ms Rosie Forster (from December 2011)	Director, Guidelines Program, NHMRC
Ms Rebecca Hughes (until August 2012)	Research Scientist, Research Implementation Program, NHMRC
Ms Stephanie Goodrick (from August 2012)	Assistant Director, Guidelines Program, NHMRC
Ms Sita Vij (until May 2012)	Project Officer, Research Implementation Program, NHMRC
Ms Jennifer Bolas (June–July 2012)	Project Officer, Research Implementation Program, NHMRC

Table 1.3 Declaration of interest

Member	Declared interests
Dr Michael Smith	Clinical director, Australian Commission on Safety and Quality in Health Care
Associate Professor Andrew Chanen	Member, guideline development committee (beyondblue), Clinical practice guidelines for depression in adolescents and young adults Member, Australian Government Department of Health and Ageing Expert Reference Group for BPD President, International Society on the Study of Personality Disorders (ISSPD) Vice President, Australian and New Zealand Association for Cognitive Analytic Therapy Chair, Organising Committee for the 12th ISSPD Congress Member, International Scientific Committee, 2nd International Congress on Borderline Personality Disorder Member, Association for Research on Personality Disorders, International Early Psychosis Association, Australasian Society for Psychiatric Research Member, International Advisory Group to the ICD-11 Working Group for the Revision of Classification of Personality Disorders Receives funding from the National Health and Medical Research Council (NHMRC), Australian Research Council (ARC), Australian Government Department of Health and Ageing and the New South Wales Ministry of Health Member, editorial boards of Personality and Mental Health and Early Intervention in Psychiatry Received honorarium for presenting at The Adelaide Clinic
Mr Fred Ford	As a carer, experienced service provision at Spectrum, The Personality Disorder Service for Victoria – bias due to positive outcomes of the service

Table 1.3 (cont.)

Member	Declared interests
Professor Brin Grenyer	Lead researcher, Project Air Strategy funded by the New South Wales Ministry of Health: Treatment of Personality Disorders Chair, Psychology Board of Australia Member, Scientific Committee, 12th International Society for the Study of Personality Disorders Congress and 6th World Congress of Psychotherapy Chair, Organising Committee for the 44th International Meeting of the Society for Psychotherapy Research Coordinator, Australia Area Group of the International Society for Psychotherapy Research and Advisory Editor of Psychotherapy Research
Professor Jane Gunn	Member, Handbook of Non-Drug Interventions working committee, Royal Australian College of General Practitioners Member, National Mental Health Service Planning Framework Committee Chair, Board of Directors, Northern Melbourne Medicare Local Member, NHMRC Research Committee Member, Mental Health Targeted Calls for Research Working Committee, NHMRC Chair, Translating Research into Practice Fellowship Review Working Committee, NHMRC Member, Mind Research Reference Group Member, beyondblue Victorian Centre of Excellence Committee Member, Medicine Insight Advisory Group, National Prescribing Service Member, National Prescribing Service Research and Development Working Group Member, Melbourne Health Primary Care and Population Health Advisory Committee Co-Editor in Chief, Journal of Comorbidity Associate Editor, BMC Family Practice Member, Primary Care Advisory Panel, British Medical Journal Member, Editorial Advisory Board, Mental Health in Family Medicine Member, Editorial Board, Asia Pacific Family Medicine Member, Editorial Board, Primary Care Mental Health Journal
Professor Mike Hazelton	Life member, Australian College of Mental Health Nurses Chair, Program and Courses Accreditation Committee, Australian College of Mental Health Nurses Member, Council of Deans of Nursing and Midwifery (Australia and New Zealand) Chair, Mental Health Nurse Education Taskforce Implementation Group, a sub-committee of the Mental Health Workforce Advisory Committee Member, Advisory Board, Australian and New Zealand Journal of Psychiatry Member, Editorial Board, International Journal of Mental Health Nursing Member, International Advisory Board, Mental Health and Substance Use Associate Editor, Nursing and Health Sciences
Dr Anthony Korner	Co-author, Borderline Personality Disorder treated by the Conversational model: a practical guide for clinicians (in press) Chair, Organising Committee for the 6th World Congress for Psychotherapy Coordinator/Acting Director, Westmead Psychotherapy Program

Table 1.3 (cont.)

Member	Declared interests
Ms Janne McMahon	Independent Chair and Executive Officer, Private Mental Health Consumer Carer Network (Australia) Member, Australian Government Department of Health and Ageing Expert Reference Group for BPD Director, Australian Psychology Accreditation Council Member, Board of Practice and Partnerships, and the Community Collaboration Committee of the Royal Australian and New Zealand College of Psychiatrists Surveyor for the Australian Council on Health Care Standards Appointed to the South Australian Health Practitioners Tribunal Contributor, and member from 4 June 2010, Trauma Informed Care and Practice Advisory Working Group
Professor Louise Newman, AM	Chair, Australian Government Department of Health and Ageing Expert Reference Group for BPD Contributor, Clinical practice guidelines for depression in adolescents and young adults Member, Organising Committee for the 6th World Congress for Psychotherapy Convenor, Alliance of Health Professionals for Asylum Seekers Chair, Detention Expert Health Advisory Group, an independent body providing advice to the Australian Government Department of Immigration and Citizenship Member, Minors Sub-Group, Council for Immigration Services and Status Resolution, Australian Government Department of Immigration
Dr Sathya Rao	Clinical director, Spectrum, The Personality Disorder Service for Victoria. Spectrum provides clinical services to patients with BPD Currently working in private practice, providing psychotherapy once a week for patients with BPD Received honoraria for providing training programs in general psychiatry Member, Organising Committee for the 12th ISSPD Congress Member, electroconvulsive therapy (ECT) training providers forum for Victoria, Chief Psychiatrist Office Current Member, Chief Psychiatrist Quality Assurance Committee for Victoria-ECT sub-committee
Ms Teresa Stevenson	Coordinator, Clinical Psychology and involved in implementing, collaborating, and participating in an international randomised clinical trial to assess the effectiveness, cost effectiveness, outcomes, and stakeholder perspectives of group and individual schema-focussed therapy for BPD Representative, Personality Disorders Interest Group of Western Australia Member, Statewide Clinical Psychology Reference Group of Western Australia Member, Statewide Early Psychosis Group, Western Australia Research collaborator on the long-term outcomes of Early Episode Psychosis Interventions in Western Australia Member, Australian Psychological Society College of Clinical Psychologists

Table 1.3 (cont.)

Member	Declared interests
Associate Professor Nicole Lee	Provided technical support in the development of the NHMRC Clinical Practice Guideline for the Management of Volatile Substance Use Development of the Australian Government practical guide for the management of complex behaviours associated with psychostimulant use Contributed to Victorian Department of Human Services Working with clients with dual mental health and substance use disorders: guidelines for alcohol and other drug workers Research funding from the Australian Government Department of Health and Ageing to improve services for people with drug and alcohol problems and mental illness: Personality disorders management in alcohol and other drugs Contracted by the NHMRC to provide methodological assistance to develop the BPD guideline
Ms Jenni Harman	Contracted by the NHMRC as a medical writer for the BPD guideline Worked on publications discussing the use of psychotropic agents, including material sponsored by pharmaceutical companies

Table 1.4 BPD Guideline Committee terms of reference (adopted January 2011)

Purpose

To produce an evidence-based, usable guideline, for the diagnosis and management of BPD and the treatment and care of people with BPD in Australia through the review and adaptation of suitable existing evidence-based international guidelines.

Role of the Committee

The role of the BPD Guideline Development Committee is to:

- determine the clinical questions to be addressed in the guideline
- consider the evidence identified by methodologist
- translate the evidence into recommendations using a formal grading system
- use a formal consensus process to make recommendations where there is disagreement
- formulate the guideline and related documents, including plans for implementation, review and update
- ensure that the guideline is a useful, applicable and implementable resource for mental healthcare professionals and mental health service providers, and that the guideline is relevant to the Australian healthcare context.

Frequency of meetings

There will be up to seven face-to-face meetings between February 2011 and June 2012. There is also provision for teleconferences to be held during this period where necessary.

Quorum

The quorum of the Committee will be 50% of appointed members, excluding the technical team (methodologist, medical writer, NHMRC support staff). No business relating to the formulation of guideline recommendations may be transacted unless the meeting is quorate.

Deliverables

By the project completion date (planned for November 2012) it is expected that there will be a clinical practice guideline for BPD suitable for use in Australian healthcare settings.

1.7.2 Adaption process

High-quality clinical guidelines for managing BPD already exist in other countries. Therefore, NHMRC developed this guideline using an established guideline methodology for adapting existing guidelines (ADAPTE),¹¹⁸ rather than developing a guideline *de novo*. The intent of the ADAPTE process is to reduce duplication of effort by using existing good quality and current guidelines as the foundation for developing a local guideline.

In accordance with the ADAPTE process, the Committee developed this guideline by adapting relevant clinical questions from a 2009 United Kingdom (UK) guideline produced by the National Institute for Health and Clinical Excellence: *Borderline personality disorder: treatment and management. National clinical practice guideline number 78* (UK national BPD clinical practice guideline).¹

The UK national BPD clinical practice guideline was selected from existing evidence-based guidelines as the most suitable source guideline for adaptation to the Australian healthcare system, using the Appraisal of Guidelines for Research and Evaluation instrument (AGREE).¹¹⁹ The AGREE instrument measures the extent to which potential bias has been adequately addressed and managed in the guideline development process, but does not assess the content of the guideline.

1.7.3 Clinical questions

This guideline was designed to answer a series of practical questions (Chapter 11) about how to treat people with BPD, how to support families and carers of people with BPD, and how the configuration of health services can best meet the needs of people with BPD. Special needs of Aboriginal and Torres Strait Islander people with BPD were also considered.

Clinical questions appropriate for literature searching, including twenty-one clinical questions adapted from the source guideline (UK national BPD clinical practice guideline)¹ and five new clinical questions, were formulated using the PICO structure (population, intervention/indicator, control/comparator, outcome). The process for formulating clinical questions is described in Appendix B.1.

Where available, information about the health economic impact of treatment options is also provided.

1.7.4 Search strategy

The methodologist developed a search strategy to identify literature to answer the clinical questions. Inclusion and exclusion criteria were developed by the methodologist in consultation with the Committee.

The source guideline (UK national BPD clinical practice guideline)¹ was based on a synthesis of level I to level III-3 evidence (systematic reviews, randomised controlled trials and comparative studies) published up to May 2008. For clinical questions addressed by the source guideline:

- the Committee reviewed and accepted the evidence synthesis provided in the source guideline. (The Committee did not seek to identify any new evidence for the period up to 2008 and did not attempt to systematically re-assess evidence identified by the source guideline).
- the body of evidence was updated by searching for literature published in English during the period 2008–2011 (Figure 1.1).^g

For new clinical questions (those not addressed by the source guideline), literature searches were conducted to identify level I to level III-3 evidence published in English during the period 2001–2011 (Figure 1.1).

^g The source guideline (UK national BPD clinical practice guideline) used a broad literature search strategy. Therefore, when updating literature searches using the PICO approach, it was not possible to replicate precisely the original search strategies for each clinical question. For updated searches, the methodologist developed search strategies based on search terms inferred from descriptions in the UK guideline, where available, in consultation with the Committee.

Systematic literature reviews were conducted for each clinical question, with the exception of clinical question 12 *‘How should complex and severe BPD be managed, including management strategies (over a period of time) and multiple comorbidities?’* from the source guideline. The Committee determined that the category ‘complex and severe’ was not clinically meaningful for Australian practice and could not be defined adequately for the purpose of literature search (see Section 5.9).

The search strategy for identifying evidence relevant to each clinical question is shown in Appendix B.2.

1.7.5 Evidence appraisal

For each study identified, the methodologist assessed the level of evidence according to NHMRC grading criteria.¹²⁰ The evidence appraisal process is detailed in Appendix B.3.

For each topic, the Committee considered evidence identified in the systematic literature review undertaken for this guideline, as well as earlier evidence presented in the UK national BPD clinical practice guideline¹ (Figure 1.1).

Recommendations were based on the body of evidence, with consideration of the strength of evidence, consistency across studies, likely clinical impact, and on the degree to which the study findings can be generalised and applied to the Australian healthcare system.

During this grading process, the Committee decided whether a graded or consensus-based recommendation could be formulated for each clinical question. Where there was insufficient evidence on which to base evidence-based recommendations (EBRs), expert opinion was taken into consideration and consensus-based recommendations (CBRs) were made, where possible.

The Committee formulated recommendations for 20 of 26 clinical questions. For those questions for which no recommendations were made, the Committee’s rationale was as follows:

- **Clinical question 3.** *What are the risk factors for BPD?* As this question does not address interventions, any relevant guidance would be derived from related question 4.
- **Clinical question 4.** *What preventative interventions are available to reduce the incidence of BPD? (as a primary or secondary outcome).* The Committee determined that there was insufficient evidence to formulate recommendations on this topic.
- **Clinical question 12.** *How should complex and severe BPD be managed, including management strategies (over a period of time) and multiple comorbidities?* The Committee determined that a literature search on the poorly defined category of ‘complex and severe’ BPD would be unlikely to yield clinically relevant evidence (see Section 1.7.4).
- **Clinical question 14.** *Among people with BPD what treatment modes of delivery are most effective in reducing suicide/self-harm, psychopathology and increasing functioning (face-to-face, group, online, self-help)?* The Committee determined that there was insufficient evidence to formulate recommendations on this topic.
- **Clinical question 19.** *Are particular therapies suited for particular service settings?* The Committee determined that there was insufficient evidence to formulate recommendations on this topic.
- **Clinical question 25.** *Do family or carers, through their behaviour, styles of relating and relationships, influence clinical and social outcomes or well-being for people with BPD?* As this question does not address interventions, guidance was provided for the related question 26 *(If so, what interventions should be offered?)*.

The Committee determined to merge clinical questions 7 '*Which psychological therapies are most effective? (CBT, mentalisation, behaviour therapy, psychodynamic, CAT, group therapy, family therapy, schema-focussed therapy, transference-focussed and DBT, miscellaneous)*' and 8 '*(Which psychosocial therapies are most effective?)*' into a single question '*(Which psychological or psychosocial therapies are most effective?)*' because there is not a clear distinction between psychosocial and psychological therapies in practice.

For the purpose of literature searching, clinical questions 11 '*Among people with BPD and comorbidities (medical [HIV/AIDS, diabetes, chronic pain, obesity, chronic fatigue], other personality disorders, other mental health, alcohol and drug disorders, eating disorders, intellectual disability) what treatments are effective in reducing suicide/self-harm, psychopathology and increasing functioning?*' and 13 '*How should the treatment of common comorbidities (depression, psychosis, anxiety disorders, bipolar disorder, substance use disorder, other axis II disorders) be altered in the presence of BPD?*' were combined.

Practice points are also provided on relevant topics that were not included in the systematic evidence review.

1.7.6 Methods used to develop consensus-based recommendations

The Committee used a modified Nominal Group Technique¹²¹ to develop recommendations for those clinical questions for which there was insufficient evidence to formulate EBRs.

The process involved the following steps:

1. Individual Committee members used their expert opinion to formulate potential recommendations.
2. The Chair asked each member of the Committee to express their expert opinions/ideas in a round robin process and all contributions were recorded.
3. Members discussed the ideas generated, organised the list to structure content and remove duplications, then drafted one or more recommendations.
4. Members gave their preliminary vote on the decision or recommendation.
5. Members discussed the vote outcome (including additions and further merging of overlaps, as necessary).
6. Members gave their final vote on the priority of items.

1.7.7 Public consultation

Public consultation was conducted from 1 April to 14 May 2012. During this period the draft guideline was available on the NHMRC website.

Notification was posted in *The Australian* national newspaper. NHMRC also invited a range of stakeholders to make submissions.

Forty-nine submissions were received. The Committee met on 7 and 8 June 2012 to consider all responses to the public consultation submissions. The draft guideline was revised where the Committee considered necessary.

1.7.8 Independent methodological review and Independent clinical expert review

The amended draft was reviewed by an independent expert in research and evidence synthesis methodology, to determine whether the Committee had properly followed NHMRC procedures and whether the final guideline met the requirements of the NHMRC 2011 standard.¹¹⁷

The draft was also reviewed by three independent clinicians with expertise in BPD management. The independent clinical reviewers considered whether the appropriate evidence was identified and reviewed in line with the stated scope and clinical questions, whether the risks and potential harms of recommendations were properly considered, and whether any conflicts between the guideline recommendations and those of other current guidance were justified by the evidence and their rationale adequately explained.

The guideline was further amended in response to recommendations from the methodological and independent clinical expert reviewers.

The final guideline was submitted to the NHMRC Council on 4 October 2012.

NHMRC approved the guideline on 25 October 2012.

1.7.9 Dissemination and implementation of the guideline

Electronic versions of the guideline and summary documents are available on the NHMRC website and the NHMRC clinical practice guidelines portal (www.clinicalguidelines.gov.au).

A mail-out to key stakeholders announcing the release of the guideline and summary documents was undertaken and included details of how to access an electronic copy or order a hardcopy version. The release of the guideline was also communicated to stakeholders through media releases, NHMRC newsletters and industry websites.

A quick reference guide version of this guideline has been created to support implementation.

Research shows that guideline implementation strategies should be multifaceted.¹²²⁻¹²⁴ Appropriate strategies for dissemination and implementation of this guideline may include attendance at conferences of health professionals, development and distribution of educational materials, and engaging opinion leaders to help promote key messages. Implementation at the local level should involve examining the barriers and enablers to best practice, and tailoring strategies accordingly to promote uptake.

1.8 Scheduled review of this guideline

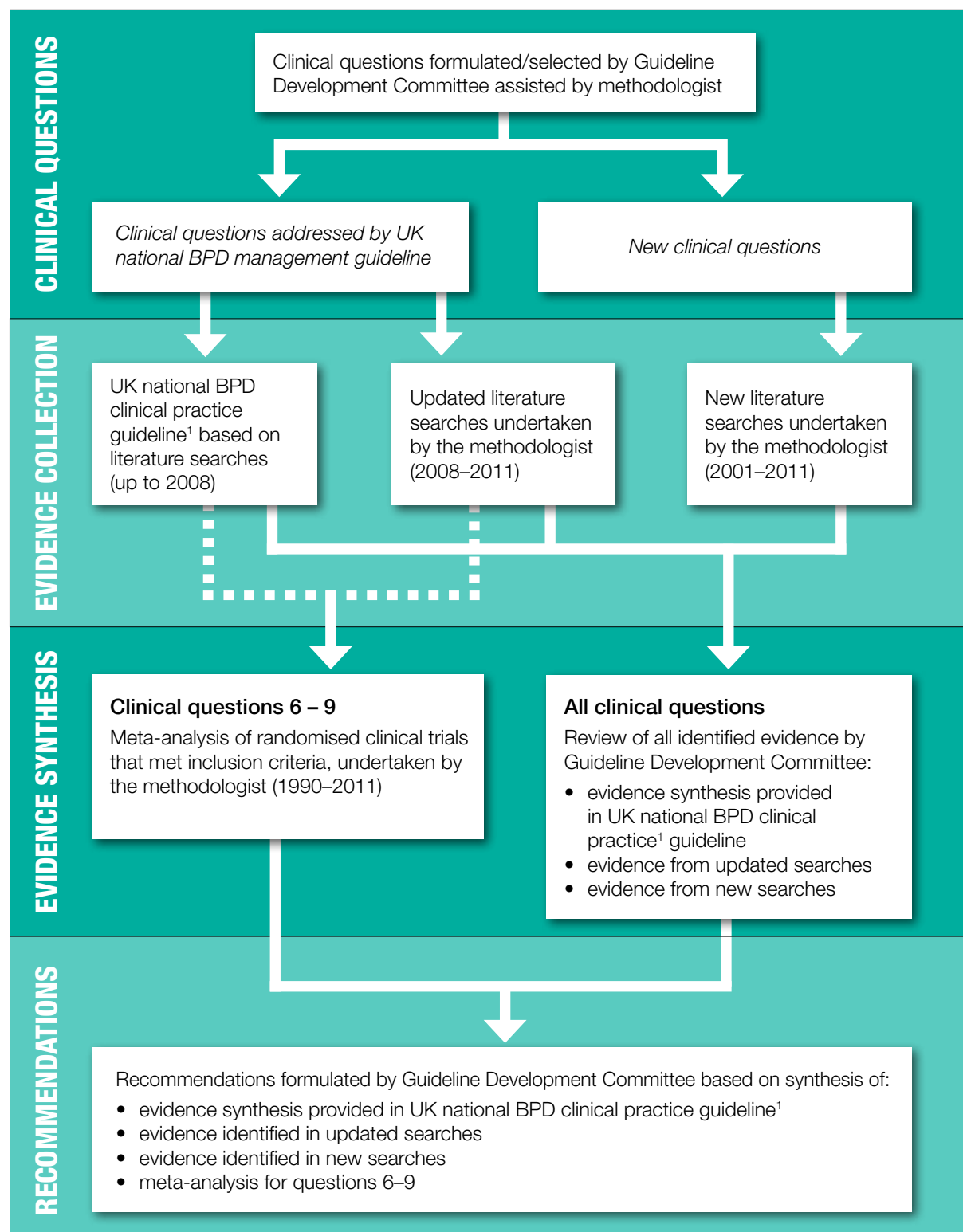
NHMRC recommends that all clinical guidelines are reviewed and revised no more than five years after initial publication. The evidence base on which the guideline was developed is likely to change significantly within this five-year period, based on the rate of publication in this field.

1.9 Funding

The development and publication of this guideline by NHMRC was funded by the Australian Government Department of Health and Ageing.

The involvement of the Department of Health and Ageing was limited to determining the scope of the guideline, and it had no involvement in the Committee's process of assessing evidence and formulating recommendations.

Figure 1.1 Process used by the committee to synthesise evidence and formulate guideline recommendations



2. Background

2.1 The diagnostic construct

2.1.1 Origins of the term

The term ‘borderline’ originally referred to a group of mental illnesses characterised by psychopathology with features of both psychosis and neurosis, but which did not clearly meet historical criteria for either group of conditions.¹²⁵ People termed ‘borderline patients’ showed extreme emotional hypersensitivity, experienced intense relationships, coped poorly with stress, and their condition was worsened by interpretive psychoanalysis as practised in the 1950s.^{81, 85, 126-128}

By the 1960s, ‘borderline personality organisation’¹²⁹ was considered to represent a broad range of psychopathology falling between psychotic personality organisation and neurotic personality organisation.⁸⁵

2.1.2 Emergence of BPD as distinct diagnostic entity

Initially, borderline conditions were thought to be closely related to schizophrenia.⁸⁵ Throughout the history of borderline diagnoses, there has been debate about its boundaries with mental state disorders such as schizophrenia,¹³⁰ depression,¹³¹ post-traumatic stress disorder^{132, 133} and bipolar disorder.^{134, 135} However, BPD is now generally thought to be distinct from these diagnoses.¹²⁶

Criteria for the objective diagnosis of BPD were published in the 1970s.^{130, 136} Diagnostic criteria for BPD were included in the 1980 edition of the American Psychiatric Association’s *Diagnostic and statistical manual of mental disorders* (DSM-III)¹³⁷ and modified in the following edition (DSM-IV).¹³⁸ The diagnosis of ‘emotionally unstable personality disorder, borderline type’ was added to the *World Health Organization’s International statistical classification of diseases and related health problems 10th Revision* (ICD-10) published in 1992.¹³⁹

2.2 Theories on the aetiology and pathogenesis of BPD

There is a range of differing theories about how BPD develops. BPD appears to be moderately heritable¹⁴⁰ and to involve a complex interplay between biological and environmental factors.^{78, 141, 142} Evidence for BPD risk factors is discussed in Section 3.1.

Various researchers and clinicians have focussed on different aspects of pathogenesis, including:^{81, 85, 126}

- links between symptoms and neurobiology^{78, 143-145}
- genetic factors that might increase risk¹⁴¹
- psychological problems that people with BPD may have in common, such as lack of capacity to reflect on one’s own mental states and mental states of other people^{146, 147} or a disturbance in self-identity^{148, 149}
- underlying developmental problems that might explain psychological problems and symptoms, such as disruption of the process of attachment between infants/children and primary caregivers in early life^{147, 150}
- the potential role of early trauma in abnormal neurodevelopment.^{133, 151}

Some researchers argue that the multidimensional problems included in the current diagnosis of BPD (e.g. emotional instability, impulsivity, cognitive problems and unstable relationships) are likely to reflect different predisposing or causal factors, and that the disorder should be redefined based on aetiology and pathogenesis when these are better understood.¹⁵²

2.3 Trauma and BPD

Health professionals need to be aware that many people with BPD have experienced significant trauma, either in the past or in their daily lives. A high proportion of people with BPD report physical or sexual abuse or neglect during childhood.^{153, 154} As adults, people with BPD also report high rates of abuse, including emotional, verbal, physical or sexual abuse.¹⁵³ Adult experiences of abuse are strongly associated with lack of remission of BPD over time.¹⁵³

Some researchers and clinicians have focussed on the interrelationship between past trauma experiences and present symptoms in people with BPD. Rates of post-traumatic stress disorder are high among people with BPD,¹⁵⁵ and some authors have argued that BPD should be regarded as 'complex post-traumatic stress disorder'.^{132, 156, 157} Among adults with BPD and co-occurring post-traumatic stress disorder, those with a history of sexual abuse during childhood or sexual assault during adulthood are less likely to experience remission from post-traumatic stress disorder.¹⁵⁸ While, in the past, research has emphasised the causal role of trauma in the development of BPD, emerging research supports multifactorial models for the development of BPD¹³³ (see Chapter 3). Not all people with BPD have experienced childhood trauma, and clinicians should not assume that trauma has occurred.

People living with and suffering from the experience of past trauma need health care that is sensitive to their complex needs and makes them feel safe while they resolve their trauma. Assessment of trauma should be done sensitively and in an appropriate context. For example, a history of past trauma should not be elicited in the emergency department during a crisis. When people with BPD have disclosed past trauma, health professionals should validate the person's experience and respond with empathy. Health professionals should only discuss past trauma with the family of a person with BPD if the person has given their consent (see Section 7.2.2).

Some clinicians and researchers have promoted trauma-focussed therapies, such as individual trauma-focussed cognitive behavioural therapy.¹⁵⁹ However, approaches focussed solely on trauma have not been demonstrated to be the most effective treatments for people with BPD.

Guidance on the management of trauma in general, or post-traumatic stress disorder, is outside the scope of this guideline. There is a national clinical practice guideline for the management of post-traumatic stress disorder.¹⁶⁰ During development of this guideline, guidance on the treatment of complex trauma and trauma-informed care and service delivery was being developed by Adults Surviving Child Abuse (ASCA).

2.4 Treatment goals for people with BPD

2.4.1 Treatment goals proposed in clinical literature

National Standards for Mental Health Services identify overarching treatment goals for people with mental illness as achieving optimal quality of life and experiencing recovery, (defined as gaining and retaining hope, understanding of one's abilities and disabilities, engagement in an active life, personal autonomy, social identity, meaning and purpose in life, and a positive sense of self).¹⁶¹

Current guidance for health professionals identifies various long-term goals of therapy for people with BPD, including:^{1, 162}

- suicide prevention
- prevention of self-harm
- avoiding the need for hospital admission
- improving relationships
- learning skills for coping
- overcoming personal problems
- personal employment and occupational goals
- ability to deal with situations that trigger emotional crises
- learning self-soothing or distraction techniques
- reducing or managing anger
- reducing depression or anxiety
- managing co-occurring conditions
- reducing or controlling problem behaviours such as impulsivity
- discovering a personal reality and developing the ability to describe and represent this reality.

2.4.2 Outcome measures used in clinical trials

Clinical trials assessing treatment in people with BPD most commonly assess changes in psychosocial functioning, aspects of psychopathology, suicidal behaviour, self-harm behaviour, and various symptoms (Table 2.1).

2.4.3 Consumer-defined treatment goals

Treating clinicians' aims may not match people's own goals for their treatment. People with BPD commonly identify overcoming emotional problems (such as depression, anxiety and anger) as a personal goal of treatment.¹⁶³

People with BPD should be involved in identifying their own treatment goals and management plans.

Table 2.1 Some outcomes measured in clinical trials assessing BPD treatments

Abstinence from alcohol and other drugs
Aggression
Anger and hostility
Anxiety
Co-occurring disorders (e.g. change in symptoms of co-occurring eating disorders, substance use disorders)
Completion of planned structured psychological therapies
Depression
Emergency service visits
Emotional control (e.g. regulation of emotions, perception of control over emotions)
Functioning (e.g. global, interpersonal, social, occupational, psychological)
Hopelessness
Impulsivity
Irritability
Medication (e.g. use of psychotropic medicines)
Mental distress
Psychiatric hospitalisation admissions
Psychopathology (various dimensions)
Quality of life
Self-injury (e.g. change in number of episodes and/or severity)
Service use
Suicide attempts and suicidal thoughts
Symptoms (e.g. individual symptoms of BPD, scores based on multiple symptoms, or overall remission from diagnostic criteria)

2.5 Considerations when interpreting the evidence

Because BPD was not formally recognised until it was included in the DSM, almost all published evidence relevant to the clinical management of BPD has appeared since 1980.⁸⁵ It is practically difficult to recruit a representative sample of people with BPD for clinical trials, because drop-out rates are high.¹

Clinical trial populations are considerably heterogeneous, because there is no agreed 'core' problem in BPD and it is defined according to operational criteria. In addition, variation in symptoms and severity is compounded by frequent co-occurring psychiatric disorders, which are often not described well in study reports.¹

Most participants in clinical trials were female, so outcomes may not be generalisable to males with BPD. No clinical trial assessing BPD treatment compared outcomes in males with those in females. Search terms to identify clinical trials in Aboriginal and Torres Strait Islander populations or culturally and linguistically diverse groups were included in literature search strategies, but no such evidence was identified.

Divergent views on the aetiology of BPD have resulted in disparate research streams and treatment models. Different treatment approaches cannot readily be compared with each other because of differences in outcome measures.

Some treatment approaches are based on theoretical concepts that are difficult to define objectively, such as mentalisation, mindfulness, schemas, transference, dialectical theory, self, ego and internal object. Effects of therapy on some of these constructs are not readily measured.

The tendency to choose concepts that are amenable to objective measurement for the purpose of empirical research may result in a relative lack of evidence from research investigating those approaches that focus on clinical psychotherapeutic experience. Adoption of behavioural criteria to measure BPD pathology and the effects of treatment may cause potentially significant interim effects to be overlooked and not understood.

Some researchers have critiqued the application of randomised controlled clinical trials to the investigation of personality disorders.¹⁶⁴ They argue that this research model is predominantly suitable for interventions that are brief and for which it is feasible to control variables. In contrast, personality change often requires relatively prolonged treatment. Several researchers have argued that other models of empirical research can be appropriately applied to the study of BPD.¹⁶⁵

It has been difficult to replicate effect sizes reported in initial studies of specific therapies. Most initial research on specific therapies is conducted by researchers who champion a particular therapy, such as clinicians who originated the treatment or their most enthusiastic colleagues. Therefore, possible explanations for initial success may include observer bias and the fact that the originator of a therapy may be more skilful in delivering it.^{1, 166}

3. Managing risk factors and preventing BPD

3.1 Risk factors for BPD

Literature was systematically searched and assessed to identify risk factors^h for BPD (clinical question 3).

The search strategy and evidence synthesis process are detailed in Appendices D to H

3.1.1 Summary of evidence: risk factors for BPD

Systematic review identified three level III studies¹⁶⁷⁻¹⁶⁹ (Table 3.1).

Table 3.1 Risk factors for BPD

Population	Summary of evidence	Level of evidence	References
Cohort of hyper-active children and control group (USA)	A small prospective cohort study followed hyperactive children and a control group. Children were assessed in 1979–1980 (ages 4–12 years), 1987–1988 (ages 12–20 years) and 1992 (ages 19–25 years). The proportion of children diagnosed with BPD was significantly higher in the hyperactive group than the control group (14% versus 3%).	III	Fischer, et al (2002) ¹⁶⁷
Cohort based on birth year and place of residence – Children in the Community study (USA)	A large prospective cohort study followed children born between the years 1965 and 1974. Children and their mothers were interviewed in 1983 (778 families), 1986 (776 families, including 34 newly located families from the 1975 cohort), and during the period 1991–1994 (776 families), at mean ages 13.7, 16.1 and 22.0 years, respectively. Maternal inconsistency in upbringing and high maternal over-involvement predicted an emergence or persistence of BPD symptoms in adolescence.	III	Cohen, et al (2008) ¹⁶⁸

^h A risk factor for BPD is defined in this guideline as a characteristic that can be measured in each person in a specified population, which can be both detected before the onset of BPD, and used to divide the population into high- and low-risk groups. [Adapted from Kraemer HC, Kazdin AE, Offord DR, et al. Coming to terms with the terms of risk. Arch Gen Psychiatry. 1997;54:337–43.]

Population	Summary of evidence	Level of evidence	References
Cohort of abused or neglected children and control group (Australia)	A large prospective cohort study followed a group of children with documented physical or sexual abuse before age 11 years, and a control group matched for age, sex, ethnicity and social class. Assessments were made during the periods 1989–1996 (aged 29 years) and 2000–2002 (aged 40 years). The rate of BPD was significantly higher among the abused group than the control group (14.9% versus 9.6%). The rate of BPD in the control group was higher than estimated for the general community. Physical abuse and neglect, but not sexual abuse, predicted BPD. Other factors associated with increased BPD risk included parental alcohol and other drug problems, diagnosis of drug abuse, major depressive disorder and posttraumatic stress disorder. These factors mediated the relationship between abuse/neglect and BPD. Welfare recipient status and parental divorce were not associated with increased BPD risk.	III	Widom, et al (2009) ¹⁶⁹

3.1.2 Discussion: risk factors for BPD

The systematic review included prospective population cohort studies, prospective cohort studies with matched control groups, and retrospective cohort studies with matched control groups. The included studies identified a number of early childhood variables that were associated with increased probability of developing BPD, including socioeconomic deprivation, trauma or stressful life events, poor or inconsistent parenting, and co-occurring psychiatric conditions.¹⁶⁷⁻¹⁶⁹

In addition to the evidence identified by the systematic review, the Committee also considered a recent narrative review of studies that have evaluated biological and environmental factors as potential risk factors for BPD (including prospective studies of children and adolescents, and studies of young people with BPD).¹⁷⁰ Evidence from these studies is summarised as follows.

3.1.2.1 Genetic risk factors

Individuals with a 'sensitive' genotype appear to be at greater risk of developing BPD when exposed to environments that predispose people to BPD. Genes that influence BPD features may also increase the risk of co-occurring illness and the risk of some adverse life events.¹⁷⁰

3.1.2.2 Environmental risk factors

A range of childhood and parental demographic characteristics, adverse childhood experiences (including neglect, trauma and abuse), early interpersonal difficulties, and forms of maladaptive parenting have been identified as risk factors for adolescent and adult BPD.¹⁶⁷⁻¹⁷¹

A large prospective cohort study (the Children in the Community study)^{154, 171, 172} in the United States of America (USA) reported that childhood physical abuse, sexual abuse or neglect, maladaptive parenting, maladaptive school experiences, and demographic characteristics (including low family socioeconomic status, family welfare support recipient status, single-parent family status) were risk factors for adolescent and adult personality disorders including BPD.

Another prospective study in the USA (the Minnesota Longitudinal Study of Risk and Adaptation),¹⁷³ which followed a cohort of low-income mothers and their babies from infancy to adulthood, reported that the number of BPD symptoms in offspring at age 28 years significantly correlated with early attachment disorganisation and maltreatment, maternal hostility and boundary dissolution, family disruption related to the father's presence, and family life stress. Maternal hostility and life stress contributed independently to the prediction of offspring BPD symptoms at age 28 years.¹⁷³

The high prevalence of disturbed attachment among adults with BPD suggests that disruption of the process of attachment between the infant/child and primary caregivers in early life may be a marker of vulnerability to BPD.¹⁵⁰ However, few prospective, longitudinal studies have investigated the effect of attachment organisation on the development of BPD to establish whether it is a risk factor.¹⁷⁰

3.1.2.3 Neurobiology and experimental psychopathology research

Neurobiological research in adults suggests that abnormalities in frontolimbic networks are associated with many of the features of BPD. However, it is unclear whether these abnormalities are a cause of BPD, an effect of BPD, or are related in some other way.¹⁷⁰

Findings from the field of experimental psychopathology have not provided clear and consistent findings that explain developmental pathways to BPD.¹⁷⁰

3.1.2.4 Precursors for BPD

Longitudinal data suggest that most adults with mental illnesses have similar mental state abnormalities (precursors)ⁱ that can be traced back to childhood and adolescence.¹⁷⁰ Evidence is emerging that BPD features such as impulsivity, negative affectivity and interpersonal aggression might become established in childhood.¹⁷⁰

A number of precursor signs and symptoms during adolescence have been associated with subsequent onset of BPD.¹⁷⁰

- Substance use disorders during adolescence, particularly alcohol use disorders, specifically predict young adult BPD.^{174, 175}
- Disruptive behaviour disorders (including conduct disorder, oppositional defiant disorder, and attention deficit hyperactivity disorder) in childhood or adolescence predict personality disorders, including BPD, in young adulthood.¹⁷⁰
- Depression in childhood or adolescence predicts personality disorders, including BPD, in young adulthood.¹⁷⁰
- Repetitive deliberate self-harm in children may be a predictor of BPD.¹⁷⁰

3.1.2.5 Non-specific factors

Evidence from some prospective and retrospective studies suggests that adverse experiences causing biological or psychosocial stress during the first few years of life increase a child's risk of a range of mental health problems and mental illnesses.¹⁷⁶⁻¹⁷⁹

i A precursor for a mental illness is defined in this guideline as a sign or symptom (from the diagnostic cluster that defines the mental illness) that does not predict the onset of the mental illness with certainty. A causal risk factor is defined as a modifiable risk factor for which there is evidence that its manipulation alters the risk for the outcome [Source: Eaton WW, Badawi M, Melton B. Prodromes and precursors: epidemiologic data for primary prevention of disorders with slow onset. *Am J Psychiatry*. 1995;152:967–72.]

3.2 Preventing BPD

Literature was systematically searched and assessed to identify interventions that might prevent people developing BPD (clinical question 4).

3.2.1 Summary of evidence: preventing BPD

No studies were identified that met the systematic review inclusion criteria.

The Committee identified one relevant study¹⁸⁰ that did not meet inclusion criteria. This study (the Children in the Community Study)¹⁵⁴ is an ongoing longitudinal study in the USA investigating the course of psychiatric disorders in a community sample. The findings were not considered by the committee of the UK national BPD clinical practice guideline¹ due to a concern about methodology: the study sample was recruited in 1975, before the inclusion of BPD in the third (1980) edition of the American Psychiatric Association's Diagnostic and statistical manual of mental disorders (DSM-III),¹³⁷ and the study investigators identified BPD retrospectively by applying a diagnostic instrument.

No other evidence was identified in the UK national BPD clinical practice guideline.¹

3.2.2 Discussion: preventing BPD

The Children in the Community study observed that a reduction in cluster B (including borderline) personality disorder symptoms was independently associated with attendance at schools characterised as 'high in learning focus' (i.e. teachers usually return marked homework and most students are interested in achieving high marks).¹⁸⁰

The Committee determined that there was insufficient evidence to formulate evidence-based recommendations on the prevention of BPD. The Committee agreed on the following considerations:

- Adolescents and young people with emerging substance use disorders, disruptive behaviour disorders, depression or self-harm should receive prompt psychosocial support and treatment as appropriate, because these may be precursors of BPD or another personality disorder.¹⁷⁰
- Given the association between disruption of the process of attachment between infant/child and primary caregivers in early life, and later development of BPD, it is possible that the risk of BPD might be reduced by interventions that improve the chance of organised attachment in infants at risk of attachment difficulties, such as those whose mothers have BPD (see Section 7.3.2.4).
- Given the evidence that adverse experiences during the first 3–4 years of life increase a child's risk of a range of mental health problems and mental illnesses, interventions targeting families at risk might help reduce BPD rates as well as rates of other conditions.

Recommendations for population-level interventions to reduce rates of child abuse and neglect (such as social policy to reduce socioeconomic deprivation, or general parenting skills programs to support at-risk families) are outside the scope of this guideline.

4. Identifying and assessing BPD

4.1 Overview: diagnostic assessment for BPD

This subsection provides general information and practice points on the diagnosis of BPD^j

4.1.1 When to suspect BPD

Symptoms of BPD typically emerge during adolescence⁸⁰ and early adulthood.⁷⁹

People with BPD may present to health services during a crisis or showing emotional distress (e.g. intense sadness, anger or anxiety), signs of recurrent self-harm, risk-taking behaviour, suicidal thoughts or suicide attempts, or may mention various relationship problems over time.¹ Assessment for BPD (or referral to mental health services for assessment) may be indicated in a person with these features.

People who repeatedly present to accident and emergency departments following acts of self-injury and other forms of self-harm are likely to have BPD.¹ Assessment by psychiatry staff and appropriate referral for full assessment may be indicated.

BPD is usually diagnosed using American Psychiatric Association Diagnostic and statistical manual of mental disorders 4th edition – text revision (DSM-IV-TR)⁷⁹ criteria (Table 4.1).^k World Health Organization International statistical classification of diseases and related health problems 10th Revision (ICD-10)¹⁸¹ also includes diagnostic criteria for unstable personality disorder, borderline type (Table 4.2).

A comprehensive and careful diagnostic assessment is essential, because treatment for people with BPD is significantly different from treatment for people with substance use, depression, post-traumatic stress disorder, bipolar disorder or psychotic symptoms who do not have BPD.

It can be challenging for less experienced health professionals to make the diagnosis accurately, because the symptoms of BPD overlap with those of other conditions such as major psychiatric disorders (e.g. depression, substance use disorders, eating disorders, post-traumatic stress disorder, bipolar disorder, psychosis) and other personality disorders (e.g. antisocial personality disorder, narcissistic personality disorder, obsessive compulsive personality disorder), and because these conditions may co-occur in a person with BPD. Although BPD has clinical features in common with these other conditions, it is distinct enough to enable experienced clinicians to make the diagnosis with confidence.

To confirm the diagnosis, it may be necessary to get a second opinion from a mental health professional who has experience in diagnosing and managing personality disorders.

^j This guideline mainly refers to diagnostic criteria for BPD according to DSM-IV-TR and its predecessors.

^k At the time of completion of this guideline, the fifth edition of the DSM had not been released and the eleventh edition of ICD was in development.

Table 4.1 DSM-IV-TR diagnostic criteria for BPD

A pervasive pattern of instability of interpersonal relationships, self-image and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following (in addition to general diagnostic criteria for a personality disorder):

1. Frantic efforts to avoid real or imagined abandonment
2. A pattern of unstable and intense interpersonal relationships characterised by alternating between extremes of idealisation and devaluation
3. Identity disturbance: markedly and persistently unstable self-image or sense of self
4. Impulsivity in at least two areas that are potentially self-damaging (e.g. spending, sex, substance abuse, reckless driving, binge eating)
5. Recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour
6. Affective instability due to a marked reactivity of mood (e.g. intense episodic dysphoria, irritability or anxiety usually lasting a few hours and only rarely more than a few days)
7. Chronic feelings of emptiness
8. Inappropriate, intense anger or difficulty controlling anger (e.g. frequent displays of temper, constant anger, recurrent physical fights)
9. Transient, stress-related paranoid ideation or severe dissociative symptoms.

Source: Diagnostic criteria for BPD from the American Psychiatric Association Diagnostic and statistical manual of mental disorders 4th edition – text revision (DSM-IV-TR) (code 301.83).⁷⁹

Table 4.2 ICD-10 diagnostic criteria for emotionally unstable personality disorder, borderline type

Emotionally unstable personality disorder is characterised by:

- a definite tendency to act impulsively and without consideration of the consequence
- unpredictable and capricious mood
- liability to outbursts of emotion and an incapacity to control the behavioural explosions
- tendency to quarrelsome behaviour and to conflicts with others, especially when impulsive acts are thwarted or censored.

Two types may be distinguished: impulsive type and borderline type.

The borderline type is characterised by disturbances in self-image, aims, and internal preferences, by chronic feelings of emptiness, by intense and unstable interpersonal relationships, and by a tendency to self-destructive behaviour, including suicidal gestures and suicide attempts.

Source: World Health Organization International statistical classification of diseases and related health problems 10th Revision (ICD-10) diagnostic criteria for the borderline type of unstable personality disorder (code F60.3).¹⁸¹

4.1.2 Initial assessment for BPD

At initial presentation, assessment should generally focus on current psychosocial functioning, and safety to self and others. Routinely, full assessment should be undertaken to identify:

- safety to self and others
- psychosocial and occupational functioning
- co-occurring mental illness (e.g. substance misuse, eating disorders)
- personality functioning
- coping strategies
- strengths and vulnerabilities
- the needs of any dependent children.

In some circumstances, the assessment process can be distressing for people with BPD. The clinician should avoid re-traumatising the person with unnecessary history taking if this can be obtained elsewhere or at follow-up. Questions about past adverse experiences should be handled sensitively.

4.1.3 Communicating the diagnosis

The diagnosis should be communicated to the person (and their family, partner or carer, if appropriate). Health professionals should only do this when they are reasonably confident that the diagnosis is correct.

Discussion of the diagnosis provides the opportunity for the person to understand their illness, request treatment and become involved in their own recovery (Table 4.3). Effective intervention may be less likely if the diagnosis is not made or recorded. Health professionals should take care to maintain a balance between validating the person's problems and experiences (placing these within the BPD framework), and promoting a view that change is possible, through a shared effort.

At the time of diagnosis, and after a thorough assessment process, the clinician should:¹⁸²

- explain which main symptoms of BPD the person has reported
- tell the person they have BPD, and explain what this condition means
- assure the person that this disorder can be treated
- give the person information about it (e.g. fact sheets, video, reliable website), and advise the person that some of the information about BPD that they may find on the internet is misleading
- invite the person to ask any questions about the diagnosis
- discuss whether the person would like to inform their family, partner or carers of their diagnosis. If so, discuss how you can best support them to do this (e.g. a consultation, providing fact sheets for families and carers).

Some people may experience distress if they are told the diagnosis at an inappropriate time or context. The diagnosis must be explained carefully, using non-technical language. The term 'borderline' is not meaningful to people with BPD and their families and friends and, for some people, it may have associations with blame and stigma. Therefore, the clinician should explain the condition in a sensitive, non-judgemental way that conveys that it is not the person's own fault, but a condition of the brain and mind that is associated with both genetic and environmental risk factors.

Table 4.3 Reasons to disclose the diagnosis of BPD to the person

Disclosure respects the person's autonomy.

People with BPD may be relieved to learn that their distress is due to a known illness.

Information about the diagnosis is necessary for psychoeducation.

Accurate diagnosis can guide treatment.

Many people will self-diagnose using information on the internet.

The diagnosis can provide optimism, because:

- it is a known condition shared by other people
- effective treatments for BPD are available
- people with BPD can recover from their symptoms.

Adapted from Beatson et al, *Borderline personality disorder: towards effective treatment* (2010)¹⁸³

4.1.4 Recommendations: diagnostic assessment

	Recommendation	Grade
R1.	Health professionals should consider assessment for BPD (or referral for psychiatric assessment) for a person with any of the following: • frequent suicidal or self-harming behaviour • marked emotional instability • multiple co-occurring psychiatric conditions • non-response to established treatments for current psychiatric symptoms • a high level of functional impairment.	PP
R2.	Once the diagnosis is established, it should be disclosed and explained to the person, emphasising that effective treatment is available.	PP
R3.	If the person agrees, the diagnosis should be explained to the person's family, partner or carers at a time that both the clinician and the person think appropriate.	PP

4.2 Identifying BPD features in young people

Literature was systematically searched and assessed to identify the most effective ways for clinicians to identify features of BPD in people aged 12–25 years (clinical question 1).

The search strategy and evidence synthesis process are detailed in Appendices D to H

4.2.1 Summary of evidence: identifying BPD features in young people

The UK national BPD clinical practice guideline¹ (in the absence of a systematic evidence review) based its guidance on identifying features of BPD on an Australian study of psychopathology in adolescents who met DSM-IV-TR⁷⁹ diagnostic criteria for BPD.¹⁸⁴

No further studies were identified by the systematic review.

4.2.2 Discussion: identifying BPD features in young people

The Committee determined that there was insufficient evidence to formulate evidence-based recommendations about identifying BPD in young people. In making consensus-based recommendations on diagnostic processes for BPD, the Committee agreed on the following considerations:

- In people aged 12–18 years, the presence of any of the following features indicates the need for a full assessment for BPD: frequent suicidal or self-harming behaviour, marked emotional instability, other psychiatric conditions (e.g. mood disorders, substance abuse disorders, disruptive behaviour disorders or anxiety disorders), non-response to established treatments for current symptoms, high level of impairment in general psychosocial functioning, self-care, and peer relationships and family relationships.^{1, 184}
- The diagnosis of BPD in a young person should only be made after comprehensive assessment by a health professional with experience and skill in the assessment of mental health problems in young people. Comprehensive assessment includes a developmental history and family history, preferably involving the young person's family, partner or carers. Health professionals should refer the person for an expert diagnostic assessment if they do not have appropriate skills and training, or are not confident to make the diagnosis.
- Although some clinicians have been concerned that it may be inappropriate to diagnose a personality disorder in a young person whose brain is still developing, current evidence shows that diagnostic criteria for BPD in a person under 18 years are as reliable and valid as in adults,^{185, 186} and the diagnosis is similarly stable over time as for adults.¹⁸⁷ BPD diagnosed in adolescence is associated with serious and persistent morbidity in adulthood.⁸⁰ Accordingly, the diagnosis can be made with reasonable confidence when a person aged 12–18 years meets diagnostic criteria for BPD.
- While the DSM-IV-TR⁷⁹ diagnosis only requires symptoms to have been present for one year, some experts have argued that the diagnosis should only be made if symptoms have been present for at least 2 years.^{187, 188}
- There is currently not enough data to support the application of diagnostic criteria for BPD to a child under 12 years.

The issue of whether or not to tell an adolescent that they have BPD has been controversial. Some health professionals have preferred to withhold the diagnosis, even when confident of its accuracy, due to concerns about stigma and discrimination the person may experience as a result of the BPD label. However, prompt disclosure of the diagnosis has potential benefits. Young people often experience relief when they learn that the difficulties they have been experiencing can be attributed to an identified syndrome and that effective treatment is available.¹⁸⁹ In general, health professionals should make the diagnosis of BPD in adolescents and young people who meet diagnostic criteria, so that early intervention can begin without unnecessary delay.¹⁸²

Note on Recommendation 5: Not all members of the Committee agreed with this recommendation. The alternative view was that the term 'BPD features' should be used instead of 'BPD' for people under 18 years.

4.2.3 Recommendations: identifying BPD features in young people

	Recommendation	Grade
R4.	Health professionals should consider assessment for BPD in people aged 12–18 years with any of the following: • frequent suicidal or self-harming behaviour • marked emotional instability • multiple co-occurring psychiatric conditions • non-response to established treatments for current psychiatric symptoms • a high level of functional impairment.	CBR
R5.	After appropriate assessment, health professionals should make the diagnosis of BPD in a person aged 12–18 years who meets the diagnostic criteria. The diagnostic criteria for BPD should not generally be applied to prepubescent children.	CBR

4.3 Diagnostic tools and assessments for BPD in young people

Literature was systematically searched and assessed to identify tools and assessment processes that can be used in clinical practice to help diagnose BPD in adolescents and young adults (clinical question 2).

The search strategy and evidence synthesis process are detailed in Appendices D to H

4.3.1 Summary of evidence: diagnostic process in young people

The UK national BPD clinical practice guideline¹ (in the absence of a systematic evidence review) based its guidance on diagnostic tools and assessments on an Australian screening study.¹⁹⁰

No further studies were identified by the systematic review.

4.3.2 Discussion: diagnostic process in young people

There is some evidence to support the use of specific self-report screening tools to identify individuals for further assessment among young people attending mental health services. The following screening instruments performed well in identifying BPD in an Australian study of people aged 15–25 years attending a mental health outpatient service, of which 22% met diagnostic criteria for BPD:¹⁹⁰

- the Borderline Personality Questionnaire (BPQ)¹⁹¹
- the BPD items from the Structured Clinical Interview for DSM-IV Axis II disorders (SCID-II)¹⁹²
- the McLean Screening Instrument for Borderline Personality Disorder (MSI-BPD)¹⁹³
- items from the International Personality Disorder Examination Screening Questionnaire.¹⁹⁴

The BPQ had the highest diagnostic accuracy and test–retest reliability.¹⁹⁰ Instruments suitable for the assessment of BPD in people aged 12–25 are listed in Table 4.4.

The Committee determined that there was insufficient evidence to formulate evidence-based recommendations on special diagnostic processes that apply to adolescents and young people.

Table 4.4 Instruments for screening BPD in young people

Borderline Personality Questionnaire ¹⁹¹
Personality Questionnaire Screen from the Structured Clinical Interview for DSM-IV Axis II disorders (15 BPD items) ¹⁹²
McLean Screening Instrument for BPD (10 items) ¹⁹³
International Personality Disorder Examination Screening Questionnaire (5 BPD items) ¹⁹⁴

Source: Chanen et al (2008)¹⁹⁰

4.3.3 Recommendations: diagnostic process in young people

	Recommendation	Grade
R6.	A thorough clinical interview should be used to diagnose BPD in young people. This can be assisted by the use of a validated semi-structured instrument.	CBR
R7.	Validated BPD screening tools can be used with young people attending mental health services to identify individuals in need of further diagnostic assessment for BPD.	CBR

4.4 Clinical and resource implications for recommendations 1–7: identifying and assessing BPD

4.4.1 Clinical implications of the recommendations

Increased rates of identification of people with features of BPD, including adolescents with early features of BPD (recommendations 4–7) in primary care and emergency departments could result in early referral to specialist, specialised and allied health services for thorough assessment and earlier diagnosis, in turn leading to prompt treatment.

4.4.2 Resource implications of the recommendations

Effective identification and referral of people with features of BPD (recommendations 1 and 4) would necessitate adequate access to referral services in all regions, and effective referral pathways to be established within each service or organisation. The availability, and affordability of such services varies across and within jurisdictions.

Early detection might lead to higher rates of BPD diagnosis and treatment. The care of people with BPD will require investment in resource additional training and services. However, early referral to effective treatment, particularly for adolescents and young people, is likely to improve long-term clinical outcomes and result in decreased utilisation of health services over the person's lifetime. In contrast, delayed or incorrect diagnosis is likely to delay effective treatment and result in high use of health services.

The diagnosis of BPD in an adolescent or young person (recommendations 5–7) requires youth mental health experience and expertise. Early detection is likely to lead to higher rates of BPD diagnosis and treatment among adolescents and young adults, who will require access to appropriate youth-oriented treatment services. Increased demand may result in a requirement for expansion of youth-oriented services and more health professionals maybe required to undergo specific training. Education and awareness-raising initiatives targeting the key professional groups may be necessary to implement the recommendations for diagnosis in adolescents.

5. Managing BPD

5.1 Psychological therapies for BPD

Literature was systematically searched and assessed to identify studies that investigated the effectiveness of various psychological therapies, including psychosocial therapies, in the management of borderline personality disorder (BPD) (clinical questions 7 and 8).

The search strategy and evidence synthesis process are detailed in Appendices D to H

5.1.1 Summary of evidence: psychological therapies

The UK national BPD clinical practice guideline¹ based its guidance on the following evidence:

- two randomised controlled trials (RCTs) of ‘brief’ psychological therapies (defined as low-intensity interventions given for less than 6 months) that compared manual-assisted cognitive therapy with treatment as usual.^{3, 4}
- six RCTs of psychological therapies delivered in outpatient settings.⁵⁻¹⁰ Therapies included Systems training for emotional predictability and problem solving (STEPPS), cognitive analytic therapy (CAT), schema-focussed psychotherapy (SFP), transference-focussed psychotherapy (TFP), cognitive-behavioural therapy (CBT), and interpersonal psychotherapy. Comparators varied between studies.
- eight RCTs of psychological therapy programs that combined more than one treatment (e.g. individual plus group therapy) and were delivered by more than one therapist.^{7, 11-17} Treatment approaches included mentalisation-based therapy (MBT) and dialectical behaviour therapy (DBT). Comparators varied between studies.
- thirteen nonrandomised trials of psychological therapies and eight nonrandomised studies of psychological therapy programs.¹

In addition, the updated systematic review identified one level I study,¹⁸ twenty-one level II studies,¹⁹⁻³⁹ and one level III study⁴⁰ (Table 5.1). Therapies included CBT, cognitive therapy (CT), DBT, dynamic deconstructive psychotherapy (DDP), emotion regulation training (ERT), interpersonal psychotherapy, general psychiatric management (a form of structured psychological therapy), MBT, motive-oriented therapeutic relationship (MOTR), psychoanalysis, psychoeducation, SFP, STEPPS, and TFP.

Meta-analysis of RCTs that compared psychological therapies with ‘treatment as usual’ was undertaken for specific outcomes. Findings of the meta-analysis are summarised in Table 5.2 and are detailed in Section 5.3 and Appendix H.

Table 5.1 Effect of psychological therapies on BPD: updated literature search

Therapy	Summary of evidence	Level of evidence	References
Various	A systematic review investigated completion rates for new treatments (1980–2009) developed for or adapted to BPD: DBT (28 studies), STEPPS (3 studies), TFP (3 studies), SFP (3 studies), CBT (2 studies), MBT (1 study), ERT (1 study), DDP (1 study). Participants included adults from inpatient, outpatient and forensic settings. Completion rates ranged from 36% to 100%; overall rate 75% for interventions <12 months duration, 71% for longer interventions.	I	Barnicot, et al (2011) ¹⁸
TFP	A RCT in 104 patients compared TFP with treatment by community psychotherapists. At one year follow-up, the treatment group showed greater reductions in BPD symptoms, greater remission rates and fewer discontinuations, compared with the control group.	II	Doering, et al (2010) ³²
DDP	A RCT in 30 adults with BPD and alcohol use disorder compared 12 months DDP (a modified form of psychodynamic psychotherapy) with TAU (various, including individual psychotherapy, medication management and alcohol counselling, group therapy and case management). At 30-month follow-up in 16 patients, the DDP group showed significant linear improvements over time in BPD symptoms and in depression, while the TAU group showed modest improvements in BPD symptoms and no change in depression.	II	Gregory, et al (2009) ³⁵ Gregory, et al (2010) ³⁴
CBT	A RCT in 134 patients with bulimia nervosa (including 38 with BPD) compared three forms of behavioural therapy following initial cognitive therapy: (i) exposure to pre-binge cues with prevention of bingeing; (ii) exposure to pre-purge cues with prevention of purging; and (iii) relaxation training. At one year follow-up, all three treatment groups showed improvements in general psychiatric functioning, with no significant difference between groups.	II	Rowe, et al (2008) ²⁴
CBT	A RCT in 106 patients with BPD compared CBT with TAU (treatment by GP and community mental health team). At six year follow-up, there was no difference between groups for rates of remission from BPD, self-harm, depression, anxiety, general psychopathology, social functioning, dysfunctional attitudes or QOL.	II	Davidson, et al (2010) ²⁵
CT	A RCT in 65 patients with BPD compared CT with Rogerian supportive therapy. At two year follow-up, there was no difference between groups in the rate of response (defined as a score of 3 or less on the Clinical Global Impression scale together with a score less than 9 on the Hopelessness Scale score), but the CT group showed significantly greater improvements in Clinical Global Impression scores than the Rogerian supportive therapy group. The CT group retained patients in therapy for longer than the Rogerian supportive therapy group.	II	Cottraux, et al (2009) ³⁸

Therapy	Summary of evidence	Level of evidence	References
MACT	A RCT in 16 patients with BPD and suicidal ideation compared MACT plus a therapeutic assessment intervention with MACT alone. Those who completed treatment (seven patients) showed significant improvements in suicidal ideation and BPD features (pre-versus post-intervention). There were no differences between groups.	II	Morey, et al (2010) ³³
DBT	A RCT in 60 women with BPD compared DBT with TAU (waitlist). DBT had no effect on rates of deliberate self-harm, hospital admissions or length of stay, but was associated with a reduction in disability and improvement in some QOL domains, compared with TAU.	II	Carter, et al (2010) ¹⁹
DBT	A RCT in 101 women with BPD and recent suicidal or self-harming behaviour with comorbid Axis I disorders compared DBT with control (behavioural psychotherapy). The proportion of Axis I disorders for which patients reached full remission did not differ between treatment groups. Among patients with substance dependence disorders, the DBT group showed a significantly higher proportion of days of abstinence than the control group. There was no difference between DBT and control groups for reductions in anxiety disorders, eating disorders, or major depressive disorder.	II	Harned, et al (2008) ²⁰
DBT	A RCT in 59 patients compared DBT with standard group therapy. Both groups showed a reduction in CGI-BPD global severity, with no difference between groups.	II	Soler, et al (2009) ²²
DBT GPM	A RCT in 180 patients compared DBT with GPM. Both treatment groups showed a reduction in BPD symptom severity, symptom distress and depression, with no significant difference between treatment groups.	II	McMain, et al (2009) ²¹
DBT	DBT for one year was provided to a cohort of 51 suicidal or self-injuring women with BPD, including 26 with PTSD who were ineligible for standard treatment due to self-harm or other problems. Of those with PTSD, 50–68% improved sufficiently to become eligible for PTSD treatment.	III	Harned, et al (2010) ⁴⁰
MBT	A RCT in 41 patients compared the combination of 18 months partial hospitalisation and MBT (individual and group) with TAU (general psychiatric outpatient care not including specialist psychotherapy and hospitalisation as needed). At eight year follow-up, the MBT group showed significant reductions in suicide attempts, emergency department visits and psychotropic medicines, and an increase in BPD remission, compared with the TAU group.	II	Bateman, et al (2008) ²⁶
MBT	A RCT in 134 patients with BPD compared 18 months MBT (individual and group) with structured clinical management. Both treatment groups showed substantial improvements in rate of crises (suicide, self-injury or hospitalisation). The MBT group showed a steeper reduction in symptoms over time.	II	Bateman, et al (2009) ²⁷

Therapy	Summary of evidence	Level of evidence	References
SFP	A RCT compared dual-focus schema therapy with drug counselling for six months in 105 therapeutic community residents with a personality disorder (including 31 with BPD) and a history of substance dependence, including 29% with a current diagnosis of DSM-IV substance dependence. Among the BPD subgroup, both treatment groups showed significant improvements in symptoms of both BPD and substance disorder during the first three months. Over the next three months the dual-focus schema therapy group showed no further improvements, while the drug counselling group continued to improve.	II	Ball, et al (2011) ²³
SFP	A RCT in 32 patients with BPD compared SFP with TAU (individual psychotherapy). At eight month follow-up, the proportion of participants who no longer met BPD criteria was significantly higher in the SFP group than the TAU group (94% vs 16%). The SFP group showed significant reductions in BPD symptoms, global severity of psychiatric symptoms, and improved global functioning, compared with baseline.	II	Farrell, et al (2009) ³⁹
STEPPS	A RCT in 79 patients with BPD compared STEPPS (group therapy) with TAU (individual outpatient therapy not including DBT). The STEPPS group showed greater reductions in general psychiatric and BPD-specific symptomatology and improvement in QOL, compared with TAU (standard treatment at non-academic outpatient units).	II	Bos, et al (2010) ²⁸
ERT	A RCT in 43 adolescents with features of BPD compared ERT with TAU (medication, individual psychotherapy, system-based therapy, inpatient psychiatric care and emergency department visits). Both groups showed reduction in BPD symptoms over time. The ERT group showed a greater improvement in sense of control over their own mood swings.	II	Schuppert, et al (2009) ²⁹
IPP	A RCT compared IPP with clinical management (fortnightly review) in 55 patients with BPD receiving fluoxetine treatment. Both treatments improved depression and overall psychosocial functioning. BPD remission rates did not differ between groups. The IPP group showed greater improvements in anxiety, psychological functioning, interpersonal relationships, affective instability and impulsivity, compared with the clinical management group.	II	Bellino, et al (2010) ³⁰
IPP	A RCT compared IPP with clinical management (fortnightly review) in 39 patients with BPD receiving fluoxetine treatment. Improvements in overall symptoms and depression did not differ between groups. The IPP group showed greater improvements in psychological functioning and social functioning, compared with the clinical management group.	II	Bellino, et al (2006) ³¹
MOTR	A RCT in 25 patients with BPD compared MOTR with TAU (manual-based psychiatric and psychotherapeutic approach). Neither treatment was associated with therapeutic benefit (pre- versus post-intervention). The MOTR group showed a greater reduction in interpersonal problems than the TAU group.	II	Kramer, et al (2011) ³⁶

Therapy	Summary of evidence	Level of evidence	References
Psycho-education	A RCT in 50 women recently diagnosed with BPD compared BPD psychoeducation with control (waitlist). Both groups showed an improvement in BPD symptoms over time, with no difference between groups. Treatment was associated with greater improvements in interpersonal storminess and general impulsivity, but not in self-harm or suicide, compared with waitlist.	II	Zanarini, et al (2008) ³⁷

CAT: cognitive analytic therapy; CBT: cognitive-behavioural therapy; CT: cognitive therapy; DBT: dialectical behaviour therapy; DDP: Dynamic deconstructive psychotherapy; ERT: Emotion Regulation Training (an adaptation of the STEPPS program); IPP: interpersonal psychotherapy; GPM: general psychiatric management (a form of structured psychological therapy); MACT: manual-assisted cognitive therapy; MBT: mentalisation-based therapy; MOTR: motive-oriented therapeutic relationship; PTSD: post-traumatic stress disorder; QOL: quality of life; RCT: randomised controlled clinical trial; TAU: treatment as usual; TFP: transference-focussed psychotherapy; SFP: schema-focussed psychotherapy; STEPPS: Systems training for emotional predictability and problem solving

Table 5.2 Summary of meta-analysis of psychological treatment trials in BPD

	Overall	CBT	DBT	DBT ST	DDP	MACT	MBT	MOTR	SFT	STEPPS	TFP
BPD symptoms	✓	–	NS ¹	✓ ¹	NS ¹	–	–	–	✓ ¹	✓	✓ ¹
General psychopathology	✓	NS ¹	✓	NS ¹	–	–	✓	NS ¹	✓ ¹	✓	NS ¹
Anger	✓	–	✓	✓ ¹	–	–	–	–	–	–	–
Depression	✓	NS ¹	✓	✓ ¹	NS ¹	–	NS	–	–	NS ¹	NS ¹
Anxiety	✓	NS ¹	✓	✓ ¹	–	–	✓ ¹	–	–	–	NS ¹
Suicidal ideation	✓	–	NS	–	–	✓ ¹	–	–	–	–	–
Self-harm and suicide	✓	✓ ¹	✓	NS ¹	NS ¹	✓ ¹	✓ ¹	–	–	–	NS ¹
General functioning	✓	NS ¹	✓	–	NS ¹	–	–	–	✓ ¹	✓	NS ¹
Interpersonal and social functioning	✓	NS ¹	NS	NS ¹	NS ¹	–	NS	✓ ¹	✓ ¹	NS	–
Hospitalisation	✓	NS ¹	NS	–	–	–	✓ ¹	–	–	–	NS ¹

Meta-analysis based on clinical trials published between 1990 and 2011 that met inclusion criteria (detailed in Appendix F).^{4, 5, 8, 11-15, 19, 22, 27, 28, 32, 34, 36, 39, 75, 195} Forest plots on which this summary is based are provided in Appendix H (separate document).

CBT: cognitive-behavioural therapy; DBT: dialectical behaviour therapy; DBT ST: dialectical behaviour therapy standard treatment; DDP: Dynamic deconstructive psychotherapy; MACT: manual-assisted cognitive therapy; MBT: mentalisation-based therapy; MOTR: motive-oriented therapeutic relationship; SFT: schema-focussed psychotherapy; STEPPS: Systems training for emotional predictability and problem solving; TFP: transference-focussed psychotherapy

✓ Statistically significant favouring treatment with more than one trial included in the analysis

✓¹ Statistically significant favouring treatment based on a single trial only

NS Non-significant with more than one trial included in the analysis

NS¹ Non-significant based on a single trial only

– Outcome not reported in trials/not included in meta-analysis

5.1.2 Discussion: psychological therapies

5.1.2.1 *Psychological treatments evaluated in randomised clinical trials*

There is a range of structured psychological therapies that are effective in the treatment of BPD, compared with treatment as usual. These include CBT,⁸ DBT,^{12, 13, 15, 19, 75} DBT skills training,²² ERT,²⁹ interpersonal psychotherapy,^{30, 31} MACT,⁴ MBT,^{11, 26, 27} MOTR,³⁶ SFP,³⁹ STEPPS,^{5, 28} and TFP.³²

The degree of improvement in outcome measures was relatively small for most therapies, compared with the comparator treatment. However, in some randomised controlled trials 'treatment as usual' was skilled care provided by clinicians experienced in BPD management. Accordingly, statistical outcomes in the randomised clinical trials may underestimate the degree of benefit to be expected from these structured psychological therapies as compared with suboptimal 'real-world' care that most people with BPD actually receive.

General psychiatric management (a form of structured psychological therapy),^{21, 165, 196-198} CAT,⁶ and an Australian form of standardised, structured, team-based clinical care ('good clinical care')⁶ have not been compared with treatment as usual in a randomised clinical trial. General psychiatric management was as effective as DBT in reducing BPD symptom severity, symptom distress and depression in a single randomised controlled clinical trial.²¹ 'Good clinical care' was as effective as CAT in improving psychopathology in people aged 14–18 with BPD or at least two DSM-IV BPD features.⁶

DBT, a multimodal treatment program that was first developed for women who self-harm¹⁹⁹ and has since been applied to other populations,¹ has been evaluated in more randomised controlled clinical trials than other structured psychological therapies.

5.1.2.2 *Other psychological therapies*

Other psychological therapies that have been developed for people with BPD are commonly advocated and practised. These therapies may have benefits, but have not been evaluated in RCTs. These include the Conversational model of psychotherapy,²⁰⁰⁻²⁰² supportive psychotherapy²⁰³ and residential treatment using a therapeutic community approach.²⁰⁴

5.1.2.3 *Characteristics of effective psychological treatments for BPD*

Effective structured therapies share the following characteristics:

- The therapy is based on an explicit and integrated theoretical approach, to which the therapist (and other members of the treatment team, if applicable) adheres, and which is shared with the person undergoing therapy.
- The therapy is provided by a trained therapist who is suitably supported and supervised (see Section 6.8).
- The therapist pays attention to the person's emotions.²⁰⁵
- Therapy is focussed on achieving change.²⁰⁵
- There is a focus on the relationship between the person receiving treatment and the clinician.²⁰⁵
- Therapy sessions occur regularly over the planned course of treatment. At least one session per week is generally considered necessary.

Structured psychological therapies are effective when delivered as individual therapy or as group therapy.

For the psychological approaches shown to be effective in randomised clinical trials, the duration of treatment ranged from 13 weeks to several years. In clinical practice, some therapies are usually continued for substantially longer periods.

5.1.2.4 Effects of specific psychological therapies on specific outcomes

The findings of the meta-analyses (Table 5.2 and Section 5.3) should be interpreted with caution due to the small number of RCTs for most treatment approaches, and inconsistency between trials for some outcome measures (details in Appendix H). Wide confidence intervals for some studies suggest relatively high variance within those study samples. Clinical trials that met inclusion criteria for meta-analysis do not demonstrate long-term effects of treatment.

Findings of the meta-analyses for specific psychological therapies included the following:

- CBT (one trial⁸) was associated with significant reductions in self-harm and suicidal behaviours, compared with treatment as usual, but no significant improvements in general psychopathology, depression, anxiety, general functioning, interpersonal and social functioning, or hospitalisation rates.
- DBT was associated with overall significant improvements in anger (four trials^{12, 15, 75, 195}), depression (two trials^{14, 15}), anxiety (three trials^{12, 15, 75}), and self-harm and suicidal behaviours (five trials^{12, 13, 15, 19, 195}), general psychopathology (two trials^{19, 75}) and general functioning (three trials^{19, 75, 195}), compared with treatment as usual, but not BPD symptoms (one trial¹²), suicidal ideation (three trials^{12, 14, 15}), interpersonal and social functioning (three trials^{19, 75, 195}), or hospitalisation rates (two trials^{15, 19}).
- DBT skills training, a modified approach based on DBT (one trial²²), was associated with significant improvements in BPD symptoms, anger, depression, and anxiety, compared with treatment as usual, but not general psychopathology, self-harm and suicidal behaviours, or interpersonal and social functioning.
- DDP (one trial³⁴) was not associated with significant improvements in any outcomes included in the meta-analysis (BPD symptoms, depression, self-harm and suicidal behaviours, general functioning, interpersonal and social functioning), compared with community-based care that did not use this approach.
- MACT (one trial⁴) was associated with significant improvements in suicidal ideation and in self-harm and suicidal behaviour, compared with treatment as usual.
- MBT was associated with significant improvements in general psychopathology (two trials^{11, 27}), anxiety (one trial¹¹), self-harm and suicidal behaviour (one trial²⁷), and hospitalisation (one trial²⁷), compared with treatment as usual, but no significant effect on depression (two trials^{11, 27}) or interpersonal and social functioning (two trials^{11, 27}).
- MOTR (one trial³⁶) was associated with a significant improvement in interpersonal and social functioning, but not general psychopathology, compared with standardised assessment not using the motive-oriented therapeutic relationship approach.
- SFP (one trial³⁹) was associated with significant improvements in BPD symptoms, general psychopathology, general functioning, and interpersonal and social functioning, compared with treatment as usual based on individual psychotherapy.
- STEPPS was associated with significant improvements in BPD symptoms (two trials^{5, 28}) general psychopathology (two trials^{5, 28}) and general functioning (two trials^{5, 28}), but not in depression (one trial⁵) or interpersonal and social functioning (two trials^{5, 28}), compared with treatment as usual.
- TFP (one trial³²) was associated with a significant reduction in BPD symptoms, but not with improvements in other included outcomes (general psychopathology, depression, anxiety, self-harm and suicidal behaviour, general functioning, hospitalisation rates), compared with treatment by an experienced community psychotherapist.

5.1.2.5 General considerations for the use of psychological BPD treatments

When considering psychological treatment for a person with BPD, the choice of treatment approach should be guided by:¹

- treatment availability and the person's preference
- the severity of psychiatric symptoms and overall impairment in psychosocial function
- the person's willingness to participate in therapy and their motivation to change
- the person's ability to remain within the boundaries of a therapeutic relationship
- the availability of professional support.

From among the effective BPD treatments, therapists should offer the treatment approach that best matches their training, theoretical framework and preferences. The effectiveness of a psychotherapy may depend on the individual therapist, and not all therapists will achieve the same results with a particular therapy.²⁰⁶

The recommendations for psychological therapies also apply to people who meet two or more diagnostic criteria for BPD and experience significant impairment in psychosocial function, even if they do not meet formal diagnostic criteria for BPD.

5.1.3 Recommendations: psychological treatments

	Recommendation	Grade
R8.	People with BPD should be provided with structured psychological therapies that are specifically designed for BPD, and conducted by one or more adequately trained and supervised health professionals.	EBR (B) ^{1, 3-40}
R9.	When planning structured psychological therapies for BPD, the therapist should adapt the frequency of sessions to the person's needs and circumstances, and should generally consider providing at least one session per week.	CBR
R10.	Health professionals should inform people with BPD about the range of BPD-specific structured psychological therapies that are available and, if more than one suitable option is available, offer the person a choice.	CBR

Evidence-based recommendation grade B: Body of evidence can be trusted to guide practice in most situations

5.2 Pharmacotherapy for BPD

Literature was systematically searched and assessed to determine the efficacy and safety profile of pharmacological treatments for BPD and co-occurring conditions (clinical question 9).

The search strategy and evidence synthesis process are detailed in Appendices D to H

5.2.1 Summary of evidence: pharmacotherapy

The UK national BPD clinical practice guideline¹ based its guidance on the following evidence:

- eight RCTs of anticonvulsant agents (carbamazepine,⁴¹ valproate^{1, 42-44} topiramate⁴⁵⁻⁴⁷ and lamotrigine⁴⁸)
- seven RCTs of antidepressant agents (fluvoxamine,⁴⁹ fluoxetine,^{31, 37, 50, 51} amitriptyline⁵² and phenelzine⁵³)
- eleven RCTs of antipsychotic agents (olanzapine,^{37, 54-58} aripiprazole,⁵⁹ ziprasidone,⁶⁰ haloperidol,^{52, 53} chlorpromazine⁶¹ and loxapine⁶¹)
- two randomised clinical trials of omega-3 fatty acids.^{62, 63}

In addition, the updated systematic review identified seven level I studies⁶⁴⁻⁷⁰ and four level II studies⁷¹⁻⁷⁴ (Table 5.3).

Meta-analysis of RCTs that compared pharmacological therapies with placebo was undertaken for specific outcomes. Findings of the meta-analysis are summarised in Table 5.4 and detailed in Section 5.3 and Appendix H.

Table 5.3 Pharmacological treatments in people with BPD: updated literature search

Agent/s	Summary of evidence	Level of evidence	References
Various	A systematic review investigated pharmacotherapy in BPD using clinical trials, reviews and meta-analyses. MAOIs was associated with a possible reduction in atypical depression, anger and impulsivity, independent of antidepressant effects. SSRIs were associated with a possible improvement in affective instability and emotional dysregulation. Lithium was associated with some benefit on core pathology, offset by toxicity. Carbamazepine was associated with improvements in a range of symptoms including impulsive, aggressive behaviour and affective dysregulation. Lamotrigine was associated with a highly significant improvement in anger after eight weeks in one clinical trial. Tiotixene, trifluoperazine, haloperidol, olanzapine and aripiprazole were associated with improvements in a range of symptoms including global symptoms, depression, anxiety, paranoid ideation, psychotic symptoms, obsessive symptoms, rejection sensitivity, impulsive aggression, and chronic dysphoria, and a reduction in suicide attempts.	I	Bellino, et al (2008) ⁶⁴

¹ In this guideline, 'valproate' is a generic term used to refer to the related compounds sodium valproate and divalproex (also termed valproate semisodium/divalproic acid). [Macritchie K, Geddes J, Scott J, Haslam DR, Goodwin G. Valproic acid, valproate and divalproex in the maintenance treatment of bipolar disorder Cochrane Database Syst Rev 2001; Issue 3.] When describing individual clinical trials, the specific preparation is stated at first mention, where specified in source.

Agent/s	Summary of evidence	Level of evidence	References
Various	A systematic review investigated pharmacotherapy in personality disorders. Antipsychotics were associated with a reduction in cognitive perceptual and mental state disturbance. Anticonvulsants were associated with a reduction in aggression.	I	Duggan, et al (2008) ⁶⁵
Various	A systematic review investigated pharmacotherapy in patients with borderline and/or schizotypal personality disorder. No medication showed effect on global functioning. Antidepressants were associated with an improvement in anxiety and anger (small effect) but no effect on impulse control or depressed mood. Assessed as a group, carbamazepine, lamotrigine, lithium, topiramate and valproate were associated with a reduction in impulsive-behavioural dyscontrol, anger, anxiety (large effects), and a reduction in depressed mood (moderate effect). This group of agents was associated with a greater improvement in global functioning, compared with antipsychotic agents.	I	Ingenhoven, et al (2010) ⁶⁶
Various	A systematic review investigated pharmacotherapy for BPD (27 clinical trials included). Findings for most agents and classes were based on single studies. No agent was associated with improvement in overall BPD severity. Antidepressant agents were not associated with improvement in BPD symptoms, except for a reduction in depression seen with amitriptyline. Haloperidol was associated with a reduction in anger. Flupenthixol was associated with a reduction in suicidal behaviour. Aripiprazole was associated with a reduction in BPD pathology. Ziprasidone was not associated with a treatment effect for any outcome. Olanzapine was associated with a higher rate of self-harm, compared with placebo. Valproate semisodium (valproate), lamotrigine and topiramate (but not carbamazepine) were associated with benefits, including reductions in anger (valproate, lamotrigine and topiramate), interpersonal problems (valproate and topiramate), and impulsivity (lamotrigine and topiramate). Omega 3 fatty acids were associated with a possible reduction in depressive symptoms.	I	Lieb, et al (2010) ⁶⁷
Various	A systematic review investigated the use of antidepressant agents, antipsychotic agents, carbamazepine, divalproic acid (valproate), lamotrigine and topiramate in BPD. Antidepressant agents were associated with a short-term reduction of depression (moderate effect). Carbamazepine, lamotrigine and topiramate (as a group) were associated with a reduction in anger (large effect). Carbamazepine and valproate were associated with a reduction in depressed mood (moderate effect). Antipsychotic agents were associated with an overall reduction in anger and depression (moderate effect), but there was some evidence that haloperidol may worsen depression.	I	Mercer, et al (2009) ⁶⁸

Agent/s	Summary of evidence	Level of evidence	References
Various	A systematic review investigated pharmacotherapy for BPD (28 clinical trials included). Findings for most agents and classes were based on single studies. No agent was associated with improvement in overall BPD severity, or in core BPD symptoms of chronic feelings of emptiness, identity disturbance and abandonment. Antidepressant agents were not associated with an improvement in BPD symptoms, except for a reduction in depression seen with amitriptyline. Haloperidol was associated with a reduction in anger. Flupenthixol was associated with a reduction in suicidal behaviours. Aripiprazole was associated with reductions in interpersonal problems, impulsivity, anger, psychotic paranoid symptoms, depression, anxiety and general psychiatric pathology. Olanzapine was associated with reductions in affective instability, anger, psychotic paranoid symptoms, and anxiety. However, olanzapine was associated with an increase in anxiety in one trial. Olanzapine was associated with a higher rate of suicidal ideation, compared with placebo. Ziprasidone was not associated with a treatment effect for any outcome. Valproate semisodium (valproate) was associated with reductions in interpersonal problems, depression and anger. Lamotrigine was associated with reductions in impulsivity and anger. Topiramate was associated with reductions in interpersonal problems, impulsivity, anger, anxiety and general psychiatric pathology. Carbamazepine was not associated with benefits.	I	Stoffers, et al (2010) ⁶⁹
Topiramate	A systematic review investigated the efficacy of topiramate in anger control. Topiramate treatment was associated with reductions in state anger, 'anger out', hostility, 'anger in', but not trait anger, compared with placebo.	I	Varghese, et al (2010) ⁷⁰
Topiramate	A 10-week RCT in 56 women with BPD compared topiramate with placebo. At 18 month follow-up (open-label phase), topiramate was associated with reductions in aggressive behaviour, anxiety and phobias, obsessiveness, depression, paranoia, interpersonal problems, pain, affective instability, health-related impediments to physical activities, physical pain, and restrictions in social and vocational activities, increases in vitality and ability to engage in specific activities, and improvements in self-assessed health and emotional state of health, compared with the control group. Topiramate did not improve psychotism.	II	Loew, et al (2008) ⁷²
Lamotrigine	An eight week RCT in 27 women with BPD compared lamotrigine with placebo. At 18 month follow-up (open-label phase), lamotrigine was associated with a reduction in anger.	II	Leiberich, et al (2008) ⁷¹
Clonidine	A double-blind placebo-controlled crossover study investigated the use of clonidine in 17 patients with BPD and hyperarousal, of which 12 had comorbid PTSD, nine had comorbid eating disorder and seven had comorbid substance abuse. Clonidine was associated with a significant 18.3% reduction in hyperarousal overall and a 21.2% reduction in the PTSD subgroup, but no significant improvement in BPD symptoms.	II	Ziegenhorn, et al (2009) ⁷⁴

Agent/s	Summary of evidence	Level of evidence	References
Olanzapine Haloperidol	An eight-week RCT in 28 women with BPD compared olanzapine with haloperidol (no placebo comparator). At 8 weeks, there were no differences between groups for scores on the Brief Psychiatric Rating Scale (BPRS), Clinical Global Impression-Severity Scale, or Buss-Durkee Hostility Inventory. At week 8, compared with baseline, both groups showed improvement in BPRS subscales for anxiety, tension, depressive mood, and hostility.	II	Shafiti, et al (2010) ⁷³

MAOI: monoamine oxidase inhibitors; PTSD: post-traumatic stress disorder; RCT: randomised controlled clinical trial; SSRI: selective serotonin reuptake inhibitors

Table 5.4 Summary of meta-analysis of pharmacotherapy trials in BPD

	Overall	Aripiprazole	Carbamazepine	Valproate ^m	Fluvoxamine	Haloperidol	Lamotrigine	Olanzapine	Phenelzine	Topiramate	Ziprasidone
BPD symptoms	NS	–	–	–	✓ ¹	NS	NS ¹	✓	NS	–	NS ¹
General psychopathology	✓	✓ ¹	NS ¹	–	–	NS	–	✓	NS	✓ ¹	NS ¹
Anger	✓	✓ ¹	–	NS	NS ¹	–	✓ ¹	NS	–	NS	NS ¹
Hostility	✓	✓ ¹	NS ¹	NS ¹	–	NS	–	✓ ¹	✓	✓ ¹	NS ¹
Irritability	✓	–	–	✓ ¹	–	–	–	✓	–	–	–
Depression	✓	✓ ¹	NS ¹	✓	–	×	–	NS	NS	NS ¹	NS ¹
Anxiety	✓	✓ ¹	NS ¹	–	–	NS ¹	–	NS ¹	NS ¹	✓ ¹	NS ¹
Suicidality and self-harm	NS	–	–	NS ¹	–	–	–	NS	–	–	NS ¹
General functioning	✓	–	NS ¹	–	–	✓	–	✓	NS	–	–
Interpersonal and social functioning	✓	✓ ¹	NS ¹	✓ ¹	–	–	–	NS	–	✓ ¹	–
Weight gain	NS	–	–	NS ¹	–	NS ¹	NS ¹	NS	NS ¹	✓*	–

Meta-analysis based on clinical trials published between 1990 and 2011 that met inclusion criteria (detailed in Appendix F).^{41–43, 45–49, 53–55, 57, 59, 60, 207, 208} Forest plots on which this summary is based are provided in Appendix H (separate document).

- ✓ Statistically significant favouring treatment with more than one trial included in the analysis
- ✓¹ Statistically significant favouring treatment based on a single trial only
- NS Non-significant with more than one trial included in the analysis
- NS¹ Non-significant based on a single trial only
- × Adverse outcome (statistically significant favouring control group with more than one trial included in the analysis)
- Outcome not reported in trials/not included in meta-analysis
- ✓* Greater weight gain in the control group

^m The preparation of valproate used in the included clinical trials was divalproex sodium/valproate semisodium. Sodium valproate is the equivalent preparation available in Australia.

5.2.2 Discussion: pharmacotherapy

5.2.2.1 Summary of randomised clinical trials of pharmacotherapy

Published systematic reviews assessing pharmacological interventions for BPD were difficult to interpret because of the small number of studies in each pharmacological class of agent, the small sample sizes in most included studies, and the fact that the heterogeneity outcomes reported made it difficult for systematic reviewers to pool data.

Overall, pharmacotherapy did not appear to be effective in altering the nature and course of the disorder. Evidence does not support the use of pharmacotherapy as first-line or sole treatment for BPD.

5.2.2.2 Effects of pharmacotherapy on specific outcomes

Placebo-controlled clinical trials of the following medicines were available for meta-analysis (Table 5.3 and Section 5.2):

- antidepressant agents including fluvoxamineⁿ (a selective serotonin reuptake inhibitor) and phenelzine (a monoamine oxidase inhibitor)
- anticonvulsant agents^o including carbamazepine, valproate,^p lamotrigine and topiramate
- antipsychotic agents^q including haloperidol, a first-generation ('conventional' or 'typical') antipsychotic agent, and the second-generation ('atypical') antipsychotic agents aripiprazole, olanzapine and ziprasidone. No studies were identified that evaluated the use of quetiapine in people with BPD.

The findings of the meta-analyses should be interpreted with caution due to the small number of trials for most individual agents and pharmacological classes, and inconsistency between trials for some outcome measures (details in Appendix H). Wide confidence intervals for some studies suggest relatively high variance within those study samples. Included clinical trials do not capture long-term effects of treatment.

Individual agents showed mixed effects on various outcomes compared with placebo, but none showed a consistent, clinically significant benefit across most relevant target outcomes. Overall, aripiprazole achieved the most consistent benefits across several outcome measures, but other agents may be useful in the management of specific symptoms.

Findings of the meta-analyses for specific medicines included the following (versus placebo):

- Among the antidepressant medicines:
 - fluvoxamine (one trial⁴⁹) was associated with an improvement in BPD symptoms, but not in anger
 - phenelzine was associated with an improvement in hostility (two trials^{53, 209}), but not in BPD symptoms (two trials^{53, 209}), general psychopathology (two trials^{53, 209}), depression (two trials^{53, 209}), anxiety (one trial⁵³), or general functioning (two trials^{53, 209}).

n Fluvoxamine is registered for the treatment of major depressive disorders and obsessive compulsive disorder, and is listed on PBS (restricted benefit).

o Topiramate and lamotrigine are not registered or PBS-listed in Australia for the treatment of BPD or the management of mood disorders. Sodium valproate and carbamazepine are not registered or PBS-listed in Australia for the treatment of BPD.

p The preparation of valproate used in the included clinical trials was divalproex sodium/valproate semisodium. Sodium valproate is the equivalent preparation available in Australia.

q Haloperidol, aripiprazole, olanzapine, ziprasidone and quetiapine are not registered or PBS-listed in Australia for the treatment of BPD.

- Among the anticonvulsant medicines:
 - carbamazepine (one trial⁴¹) was not associated with significant improvements in any of the outcomes included (general psychopathology, hostility, anxiety, depression, general functioning, and interpersonal and social functioning)
 - valproate^r was associated with significant improvements in irritability (one trial⁴³), depression (two trials^{42, 43}) and in interpersonal and social functioning (one trial⁴²), but not in anger (two trials^{42, 43}), hostility (one trial⁴²), or suicidality (one trial⁴³)
 - lamotrigine was associated with a significant improvement in anger (one trial⁴⁸) but not BPD symptoms (one trial²⁰⁷)
 - topiramate was associated with a significant improvement in general psychopathology (one trial⁴⁵), hostility (one trial⁴⁵), anxiety (one trial⁴⁵) and in interpersonal and social functioning (one trial⁴⁵), but not in anger (two trials^{46, 47}) or depression (one trial⁴⁵).
- Among the antipsychotic medicines:
 - haloperidol was associated with a significant improvement in general functioning two trials^{53, 208}), but a significant worsening of depression (two trials^{53, 208}), and no change in BPD symptoms (two trials^{53, 208}), general psychopathology (two trials^{53, 208}), hostility (two trials^{53, 208}) or anxiety (one trial⁵³)
 - aripiprazole (one trial⁵⁹) was associated with significant improvements in general psychopathology, anger, hostility, depression, anxiety, and in interpersonal and social functioning
 - olanzapine was associated with improvements in BPD symptoms (two trials^{55, 57}), general psychopathology (two trials^{55, 57}), hostility (one trial⁵⁷) and irritability (one trial⁵⁷), and general functioning (two trials^{55, 57}), but not anger (three trials^{54, 55, 57}), depression (one trial⁵⁴), anxiety (one trial⁵⁴), suicidality (two trials^{55, 57}) or interpersonal and social functioning (two trials^{54, 55}). Based on pooled data from four trials,⁵⁴⁻⁵⁷ olanzapine was not associated with significantly more weight gain than placebo.
 - ziprasidone (one trial⁶⁰) was not associated with significant improvements in any of the included outcomes (BPD symptoms, general psychopathology, anger, hostility, depression, anxiety, or suicidality).

The Committee determined that reliable evidence-based recommendations could not be made about the use of a particular agent to target specific outcomes where fewer than three randomised placebo-controlled clinical trials were available for meta-analysis.

5.2.2.3 General considerations for the use of pharmacotherapy in BPD

Any pharmacological treatment for a person with BPD should be part of a documented management plan and should be reviewed regularly for therapeutic and adverse effects. When selecting medicines, the prescriber and person with BPD should discuss and agree on specific goals of treatment.

Before prescribing any medicine for a person with BPD, prescribers should carefully consider potential interactions with alcohol and other substances, potential drug-to-drug interactions with other prescription and non-prescription medicines, and potential adverse effects in overdose. People with BPD are at elevated risk of attempted suicide using prescription medicines²¹⁰ (e.g. monoamine oxidase inhibitors, tricyclic antidepressant agents, lithium).

Use one medicine at a time and avoid polypharmacy. Review its efficacy and discontinue before trialling another medicine.

^r The preparation of valproate used in the included clinical trials was divalproex sodium/valproate semisodium. Sodium valproate is the equivalent preparation available in Australia.

If medicines are prescribed to manage acute crisis, the management plan should specify dose and duration of treatment. The length of crises may vary.

Health professionals should explain to people with BPD that medicines only have a limited role in the management of BPD and may have unwanted effects.

BPD is not listed as an approved indication for any medicine licensed in Australia by the Therapeutic Goods Administration, nor is any medicine reimbursed by the Pharmaceutical Benefits Scheme specifically for the treatment of BPD.

5.2.2.4 Pharmacotherapy in acute management of crises

No RCTs were identified that compared different pharmacotherapeutic regimens in the management of acute crises in people with BPD.

When medicines are used to help manage a crisis, they should be withdrawn after the crisis has been resolved (e.g. over hours to weeks, depending on the person's needs). The course of treatment, including dose, planned duration and review intervals, should be clearly documented and communicated to other prescribers involved in the person's care.

5.2.3 Recommendations: pharmacotherapy

	Recommendation	Grade
R11.	Medicines should not be used as primary therapy for BPD, because they have only modest and inconsistent effects, and do not change the nature and course of the disorder.	EBR (B) ^{1, 31, 37, 41-74}
R12.	The time-limited use of medicines can be considered as an adjunct to psychological therapy, to manage specific symptoms.	CBR
R13.	Caution should be used if prescribing medicines that may be lethal in overdose, because of high suicide risk with prescribed medicines among people with BPD.	PP
R14.	Caution should be used if prescribing medicines associated with substance dependence.	PP
R15.	Before starting time-limited pharmacotherapy for people with BPD: • ensure that a medicine is not used in place of other, more appropriate interventions • take account of the psychological role of prescribing (both for the individual and for the prescriber) and the impact that prescribing decisions may have on the therapeutic relationship and the overall BPD management plan, including long-term treatment strategies • use a single medicine and avoid polypharmacy, if possible • ensure that there is consensus among prescribers about the medicine used, and collaboration with other health professionals involved in the person's care, and that the main prescriber is identified • establish likely risks of prescribing, including interactions with alcohol and other substances.	PP
R16.	The use of medicines can be considered in acute crisis situations where psychological approaches are not sufficient.	PP
R17.	If medicines have been prescribed to manage a crisis, they should be withdrawn once the crisis is resolved.	PP

Evidence-based recommendation grade B: Body of evidence can be trusted to guide practice in most situations.

5.3 Targeting specific outcomes

Literature was systematically searched and assessed to identify treatments that improve mental state, quality of life, or psychosocial functioning, or reduce self-harm, suicide or avoidable healthcare service use (such as unplanned hospital admissions) in people with borderline personality disorder (BPD), while minimising harms (clinical question 6).

The search strategy and evidence synthesis process are detailed in Appendices D to H

This section summarises evidence for the effects of psychological and pharmacological treatments on a range of specific outcome measures.

For an overview of evidence on psychological therapies in BPD and general recommendations for their use, refer to Section 5.1.

For an overall overview of evidence on pharmacotherapy in BPD and general recommendations for their use, refer to Section 5.2.

5.3.1 Summary of evidence: targeting specific outcomes

The UK national BPD clinical practice guideline¹ considered evidence for the effect of BPD treatments on the following specific outcomes: anger,^{13,46–48,57,59} aggression,^{43,44,55,57,63,211} hostility,^{41,42,45,52,53,59} anxiety,^{8,11,12,45,54,60,212} depression,^{8,11,12,14,41–43,45,52–54,59,60,63,211} impulsiveness,^{5,52,53,60} mental distress,^{5,8,11,52,55,57,59} self-harm and suicide-related measures,^{4–6,8,11–17,55,57,62,63,212} use of healthcare services,^{5,8,11,13–15,17} BPD symptomatology,^{5,11,12,55,57,213} psychopathology outcomes,^{41,60} social functioning,^{8,214} general functioning,^{5,11,53,212} employment,¹¹ quality of life,^{8,9} and various adverse effects reported in clinical trials of medicines.

In addition, the updated systematic review identified:

- seven level I studies^{64–70} and seventeen level II studies^{19,21,22,25–30,32,33,37–39,71–73} that reported effects of interventions on mental state (Table 5.5)
- Five level II studies^{19,21,25,28,30} that reported effects of interventions on quality of life (Table 5.6)
- Three level I studies^{64,67,69} and ten level II studies^{19,21,22,25–28,32,33,71} that reported effects of interventions on self-harm (Table 5.7)
- eight level II studies^{19,21,22,25–28,32} that reported effects of interventions on use of healthcare services (Table 5.8)
- Four level I studies^{66,67,69,70} and thirteen level II studies^{21,25–30,32,36–39,72} that reported effects of interventions on social and/or interpersonal functioning (Table 5.9).

Meta-analyses of RCTs were undertaken for the following outcomes: BPD symptoms, mental state outcomes (general psychopathology, anger, hostility, irritability, depression, anxiety and suicidal ideation), self-harm and suicide, psychosocial functioning (general functioning, interpersonal and social functioning), and hospitalisation. The meta-analyses included placebo-controlled

pharmacotherapy trials and psychological intervention trials that compared the study treatment with 'treatment as usual'. It considered for inclusion all trials identified in the UK national BPD clinical practice guideline¹ and the updated systematic review. Findings are summarised in Tables 5.2 and 5.4 and detailed in Appendix H.

The meta-analysis is described in Appendix F and forest plots provided in Appendix H

Table 5.5 Effect of BPD interventions on mental state: updated literature search

Interventions	Summary of evidence	Level of evidence	References
TFP	Higher remission rates, but no difference in the degree of improvement in depression or anxiety, compared with treatment by community psychotherapists. Significant improvements in depression and anxiety, pre- versus post-treatment in both groups.	II	Doering, et al (2010) ³²
MBT	Higher remission rates and greater improvements in affect, cognitive function and impulsivity, compared with TAU (general psychiatric outpatient care, community support from mental health nurses, inpatient treatment as necessary, no specialist psychotherapy).	II	Bateman, et al (2008) ²⁶
MBT	Greater reductions in interpersonal distress (large effect), symptom distress (moderate effect), depression (small effect), compared with structured clinical management.	II	Bateman, et al (2009) ²⁷
DBT	Greater improvements in depression, anxiety, anger and general psychiatric symptoms, compared with standard group therapy. A significant improvement in CGI-BPD subscales for psychoticism and irritability, pre- versus post-DBT.	II	Soler, et al (2009) ²²
DBT	No effect on mental state measures, compared with TAU (waitlist).	II	Carter, et al (2010) ¹⁹
DBT GPM	Both treatments: reductions in BPD symptom severity, symptom distress and depression (pre- versus post-intervention). No significant difference between treatment groups.	II	McMain, et al (2009) ²¹
ERT	An improvement in the feeling of having control over emotions (pre- versus post-intervention) in ERT group but not TAU group. No effect on affective stability, compared with TAU (medication, individual psychotherapy, system-based therapy, inpatient psychiatric care and emergency department visits).	II	Schuppert, et al (2009) ²⁹
MACT	A reduction in affective instability among those who completed treatment, but high drop-out rate (pre- versus post-intervention). MACT not compared with another treatment.	II	Morey, et al (2010) ³³

Interventions	Summary of evidence	Level of evidence	References
SFP	Reductions in BPD symptoms, global severity of psychiatric symptoms, and improved global functioning (improvement in Borderline Syndrome Index, SCL-90, Diagnostic Interview for Borderline Personality Disorders-Revised and Global Assessment of Function Scale), compared with baseline. No significant improvements in control (TAU) group, compared with baseline.	II	Farrell, et al (2009) ³⁹
STEPPS	Greater improvements in SCL-90 and BPD-40 scores, compared with TAU (standard treatment at non-academic outpatient units).	II	Bos, et al (2010) ²⁸
CBT	No effect on depression, anxiety, general psychopathology at six year follow-up, compared with TAU (treatment by GP and community mental health team).	II	Davidson, et al (2010) ²⁵
CT	Improvements in Hopelessness Scale and Clinical Global Impression scale, compared with control (Rogerian supportive therapy).	II	Cottraux, et al (2009) ³⁸
Psycho-education	A greater improvement in general impulsivity, compared with waitlist.	II	Zanarini, et al (2008) ³⁷
Pharmacotherapy (various agents)	MAOIs: possible reductions in atypical depression, anger and impulsivity, independent of antidepressant effects. SSRIs: possible improvements in affective instability and emotional dysregulation. Lithium: some benefit on core pathology, but potential toxicity (including potential for fatal overdose). Carbamazepine: improvements in a range of symptoms including impulsive aggressive behaviour and affective dysregulation. Lamotrigine: a highly significant improvement in anger after eight weeks in one clinical trial. Tiotixene, trifluoperazine, haloperidol, olanzapine and aripiprazole: improvements in a range of symptoms including global symptoms, depression, anxiety, paranoid ideation, psychotic symptoms, obsessive symptoms, rejection sensitivity, impulsive aggression, and chronic dysphoria. Risperidone: no effect on symptoms.	I	Bellino, et al (2008) ⁶⁴
Pharmacotherapy (various agents)	Antipsychotics: reductions in cognitive perceptual and mental state disturbance. Anticonvulsants: a reduction in aggression.	I	Duggan, et al (2008) ⁶⁵
Pharmacotherapy (various agents)	Antidepressant agents: a short-term reduction of depression (moderate effect). Carbamazepine, lamotrigine and topiramate (as a group) associated with a reduction in anger (large effect). Carbamazepine and divalproic acid (valproate) were associated with a reduction in depressed mood (moderate effect). Antipsychotics: overall reductions in anger and depression (moderate effect), but some evidence that haloperidol may worsen depression.	I	Mercer, et al (2009) ⁶⁸

Interventions	Summary of evidence	Level of evidence	References
Pharmacotherapy (various agents)	Antidepressant agents: improvements in anxiety and anger (small effect) but no effect on impulse control or depressed mood. Carbamazepine, lamotrigine, lithium, topiramate and valproate (assessed as a group): reductions in impulsive behavioural dyscontrol, anger, anxiety (large effects), a reduction in depressed mood (moderate effect).	I	Ingenhoven, et al (2010) ⁶⁶
Pharmacotherapy (various agents)	Systematic review investigating pharmacotherapy for BPD (27 clinical trials included). Findings for most agents and classes based on single studies. Amitriptyline (but not other antidepressant agents) associated with a reduction in depression. Haloperidol associated with a reduction in anger. Valproate semisodium (valproate), lamotrigine and topiramate associated with a reduction in anger. Lamotrigine and topiramate associated with a reduction in impulsivity. Omega 3 fatty acids associated with a possible reduction in depressive symptoms.	I	Lieb, et al (2010) ⁶⁷
Pharmacotherapy (various agents)	A systematic review investigating pharmacotherapy for BPD (28 clinical trials included). Findings for most agents and classes were based on single studies. Amitriptyline (but not other antidepressant agents) associated with a reduction in depression. Haloperidol associated with a reduction in anger. Aripiprazole associated with reductions in impulsivity, anger, depression and anxiety. Olanzapine associated with a reduction in affective instability, anger and anxiety (but olanzapine associated with an increase in anxiety in one trial). Valproate semisodium (valproate) associated with reductions in depression and anger. Lamotrigine associated with reductions in impulsivity and anger. Topiramate associated with reductions in impulsivity, anger and anxiety.	I	Stoffers, et al (2010) ⁶⁹
Topiramate	Reductions in state anger, 'anger out', hostility, 'anger in', but not trait anger, compared with placebo.	I	Varghese, et al (2010) ⁷⁰
Topiramate	Reductions in aggressive behaviour, anxiety and phobias, obsessiveness, depression, paranoia, affective instability, but no effect on psychotic symptoms, compared with control (placebo followed by no pharmacotherapy).	II	Loew, et al (2008) ⁷²
Lamotrigine	Reductions in anger or aggression, compared with placebo.	II	Leiberich, et al (2008) ⁷¹

Interventions	Summary of evidence	Level of evidence	References
Olanzapine Haloperidol	Both treatments: improvements in anxiety, tension, depressive mood, hostility. No differences between treatments.	II	Shafiti, et al (2010) ⁷³
Fluoxetine IPP	Fluoxetine plus IPP: greater improvements in impulsivity and affective instability, compared with fluoxetine plus clinical management. Fluoxetine plus IPP and fluoxetine plus clinical management: a reduction in depression. No difference between treatments for remission rates.	II	Bellino, et al (2010) ³⁰

BPD-40: Borderline Personality Disorder checklist-40; CBT: cognitive-behavioural therapy; CT: cognitive therapy; DBT: dialectical behaviour therapy; ERT: emotion regulation training (an adaptation of the STEPPS program); CGI-BPD: Clinical Global Impression-BPD scale; IPP: interpersonal psychotherapy; GPM: General psychiatric management (a form of structured psychological therapy); MACT: manual-assisted cognitive therapy; MAOIs: monoamine oxidase inhibitors; MBT: mentalisation-based therapy; SCL-90: Symptoms Check List-90; SFP: schema-focussed psychotherapy; SSRI: selective serotonin reuptake inhibitor; TAU: treatment as usual; TFP: transference-focussed psychotherapy; STEPPS: systems training for emotional predictability and problem solving;

Table 5.6 Effect of BPD interventions on quality of life: updated literature search

Interventions	Summary of evidence	Level of evidence	References
CBT	No effect on QOL at six year follow-up, compared with TAU (treatment by GP and community mental health team).	II	Davidson, et al (2010) ²⁵
DBT	Greater improvements in three of four QOL domains, compared with TAU (waitlist).	II	Carter, et al (2010) ¹⁹
DBT GPM	Both treatments: an improvement in health-related QOL (pre- versus post-intervention). No difference between treatments.	II	McMain, et al (2009) ²¹
STEPPS	Greater improvements in overall QOL, general health, physical health and psychological health, compared with TAU (standard treatment at non-academic outpatient units).	II	Bos, et al (2010) ²⁸
Fluoxetine IPP	Fluoxetine plus IPP: greater improvements in social and psychological functioning domain of QOL scale, compared with fluoxetine plus clinical management.	II	Bellino, et al (2010) ³⁰

CBT: cognitive-behavioural therapy; GPM: general psychiatric management (a form of structured psychological therapy); IPP: interpersonal psychotherapy; QOL: quality of life; TAU: treatment as usual; STEPPS: systems training for emotional predictability and problem solving

Table 5.7 Effect of BPD interventions on suicide and self-harm: updated literature search

Interventions	Summary of evidence	Level of evidence	References
TFP	Reductions in suicide and self-harm attempts, compared with treatment by community psychotherapists.	II	Doering, et al (2010) ³²
CBT	A reduction in suicide attempts (1.26 fewer attempts) at six year follow-up, compared with TAU (treatment by GP and community mental health team).	II	Davidson, et al (2010) ²⁵
DBT	No effect on self-harm or suicide, compared with standard group therapy.	II	Soler, et al (2009) ²²
DBT	No effect on self-harm, compared with TAU (waitlist).	II	Carter, et al (2010) ¹⁹
DBT GPM	Both treatments: reductions in suicide and medical risk (pre- versus post-intervention). No difference between groups.	II	McMain, et al (2009) ²¹
MBT	A reduction in suicide attempts at five year follow-up post therapy, compared with TAU (general psychiatric outpatient care, community support from mental health nurses, inpatient treatment as necessary, no specialist psychotherapy).	II	Bateman, et al (2008) ²⁶
MBT	A greater reduction in frequency of self-harm, higher rate of achieving six months free of suicidal behaviour, self-harm or hospitalisation, compared with structured clinical management. A reduction in suicidal behaviour in both groups (pre- versus post-intervention).	II	Bateman, et al (2009) ²⁷
MACT	Reductions in suicide and self-harm among those who completed treatment (pre- versus post-intervention). MACT not compared with another treatment.	II	Morey, et al (2010) ³³
STEPPS	No effect on suicide, compared with TAU (standard treatment at non-academic outpatient units).	II	Bos, et al (2010) ²⁸
Pharmacotherapy (various agents)	Tiotixene, trifluoperazine, haloperidol, olanzapine, aripiprazole: a reduction in suicide attempts.	I	Bellino, et al (2008) ⁶⁴
Pharmacotherapy (various agents)	Systematic review investigating pharmacotherapy for BPD (27 clinical trials included). Findings for most agents and classes based on single studies. Flupenthixol associated with a reduction in suicidal behaviour. Olanzapine associated with a higher rate of self-harm, compared with placebo.	I	Lieb, et al (2010) ⁶⁷

Interventions	Summary of evidence	Level of evidence	References
Pharmacotherapy (various agents)	A systematic review investigating pharmacotherapy for BPD (28 clinical trials included). Findings for most agents and classes were based on single studies. Flupenthixol associated with a reduction in suicidal behaviours.	I	Stoffers, et al (2010) ⁶⁹
Lamotrigine	Adverse events included self-harm in lamotrigine group and attempted suicide in placebo group.	II	Leiberich, et al (2008) ⁷¹

CBT: cognitive-behavioural therapy; GPM: general psychiatric management (a form of structured psychological therapy); MACT: manual-assisted cognitive therapy; MBT: mentalisation-based therapy; TAU: treatment as usual; TFP: transference-focussed psychotherapy; STEPPS: systems training for emotional predictability and problem solving

Table 5.8 Effect of BPD interventions on use of healthcare services: updated literature search

Interventions	Summary of evidence	Level of evidence	References
MBT	A reduction in hospital visits, a reduction in use of psychiatric medicines (including antipsychotic agents, antidepressant agents and other agents prescribed to regulate mood), an increase in rate of psychological therapy at five year follow-up post therapy, compared with TAU (general psychiatric outpatient care, community support from mental health nurses, inpatient treatment as necessary, no specialist psychotherapy).	II	Bateman, et al (2008) ²⁶
MBT	A greater reduction in hospital admissions, compared with structured clinical management. A reduction in hospital admissions both treatment groups (pre- versus post-intervention).	II	Bateman, et al (2009) ²⁷
STEPPS	Fewer contacts with mental healthcare professionals (e.g. psychiatrists, psychologists, psychiatric nurses, social workers) other than main clinician providing BPD treatment (not including planned treatment sessions), compared with TAU (standard treatment at non-academic outpatient units).	II	Bos, et al (2010) ²⁸
DBT	No significant reductions in hospitalisation rate or length of hospital admissions, compared with TAU (waitlist).	II	Carter, et al (2010) ¹⁹
CBT	Reduced mean length of hospital admissions at six year follow-up, compared with TAU (treatment by GP and community mental health team).	II	Davidson, et al (2010) ²⁵
TFP	A reduction in the number and length of psychiatric inpatient treatments, compared with treatment by community psychotherapists.	II	Doering, et al (2010) ³²

Interventions	Summary of evidence	Level of evidence	References
DBT GPM	DBT: a greater reduction in use of non-study treatments, compared with GPM. Both treatments: reductions in emergency department visits and psychiatric inpatient days (pre- versus post-intervention).	II	McMain, et al (2009) ²¹
DBT	No effect on emergency department visits, compared with standard group therapy.	II	Soler, et al (2009) ²²

CBT: cognitive-behavioural therapy; GPM: general psychiatric management (a form of structured psychological therapy); MBT: mentalisation-based therapy; TAU: treatment as usual; TFP: transference-focussed psychotherapy; STEPPS: systems training for emotional predictability and problem solving

Table 5.9 Effect of BPD interventions on social and interpersonal functioning: updated literature search

Interventions	Summary of evidence	Level of evidence	References
TFP	An improvement in psychosocial functioning, compared with treatment by community psychotherapists.	II	Doering, et al (2010) ³²
CBT	No effect on social functioning or dysfunctional attitudes at six year follow-up, compared with TAU (treatment by GP and community mental health team).	II	Davidson, et al (2010) ²⁵
CT	An improvement in Clinical Global Impression scale, compared with control (Rogerian supportive therapy).	II	Cottraux, et al (2009) ³⁸
DBT GPM	Both treatments: a reduction in interpersonal problems (pre-versus post-intervention).	II	McMain, et al (2009) ²¹
MBT	Greater improvements in interpersonal functioning, employment and vocational measures at five year follow-up post therapy, compared with TAU (general psychiatric outpatient care, community support from mental health nurses, inpatient treatment as necessary, no specialist psychotherapy).	II	Bateman, et al (2008) ²⁶
MBT	A greater improvement in global function, compared with structured clinical management.	II	Bateman, et al (2009) ²⁷
SFP	Improvements in interpersonal subscale of Borderline Personality Disorders-Revised, and Global Assessment of Function Scale, compared with baseline. No significant improvements in control (TAU) group, compared with baseline.	II	Farrell, et al (2009) ³⁹
Psycho-education	A greater reduction in 'interpersonal storminess', compared with waitlist.	II	Zanarini, et al (2008) ³⁷
ERT	An improvement in internal locus of control, compared with TAU (medication, individual psychotherapy, system-based therapy, inpatient psychiatric care and emergency department visits).	II	Schuppert, et al (2009) ²⁹

Interventions	Summary of evidence	Level of evidence	References
STEPPS	No overall effect on social relationships domain (measured by QOL instrument), compared with TAU (standard treatment at non-academic outpatient units).	II	Bos, et al (2010) ²⁸
MOTR	A greater reduction in interpersonal problems, compared with manual-based investigation without MOTR.	II	Kramer, et al (2011) ³⁶
Pharmacotherapy (various agents)	A systematic review investigated pharmacotherapy for BPD (27 clinical trials included). Findings for most agents and classes were based on single studies. Valproate semisodium (valproate) and topiramate were associated with improvements in interpersonal problems.	I	Lieb, et al (2010) ⁶⁷
Pharmacotherapy (various agents)	A systematic review investigating pharmacotherapy for BPD (28 clinical trials included). Findings for most agents and classes based on single studies. Aripiprazole, valproate semisodium (valproate) and topiramate associated with improvements in interpersonal problems.	I	Stoffers, et al (2010) ⁶⁹
Pharmacotherapy (various agents)	No medication showed effect on global functioning. Carbamazepine, lamotrigine, lithium, topiramate and valproate (assessed as a group): greater effect on global functioning, compared with antipsychotics.	I	Ingenhoven, et al (2010) ⁶⁶
Topiramate	Reductions in state anger, 'anger out', hostility, 'anger in', but not trait anger, compared with placebo.	I	Varghese, et al (2010) ⁷⁰
Topiramate	Improvement in health and activity-related measures, compared with control (placebo followed by no pharmacotherapy).	II	Loew, et al (2008) ⁷²
Fluoxetine IPP	Fluoxetine plus IPP: greater improvements in social and psychological functioning (measured on QOL scale), compared with fluoxetine plus clinical management. Fluoxetine plus IPP and fluoxetine plus clinical management: an improvement in global functioning (pre- versus post-intervention). Fluoxetine plus IPP: an improvement in interpersonal relationships (pre- versus post-intervention).	II	Bellino, et al (2010) ³⁰

CBT: cognitive-behavioural therapy; CT: cognitive therapy; ERT: emotion regulation training (an adaptation of the STEPPS program); GPM: general psychiatric management (a form of structured psychological therapy); IPP: interpersonal psychotherapy; MBT: mentalisation-based therapy; MOTR: motive-oriented therapeutic relationship; QOL: quality of life; TAU: treatment as usual; TFP: transference-focussed psychotherapy; SFP: schema-focussed psychotherapy; STEPPS: systems training for emotional predictability and problem solving

5.3.2 Discussion: targeting specific outcomes

5.3.2.1 Quality of the data

Published systematic reviews that reported effects of BPD interventions on specific outcome measures were difficult to interpret because of the variation in included studies, the small number of studies for each treatment approach, the small sample sizes in most included studies, and the fact that the heterogeneity outcomes reported made it difficult for systematic reviewers to pool data.⁶⁴⁻⁷⁰

The findings of the meta-analysis (Tables 5.2 and 5.4) should be interpreted with caution due to the small number of trials for most treatment approaches, and inconsistency between trials for some outcome measures. Where more than one study was available for a particular outcome, they were often by the same research group, making it difficult to determine whether the reported results were due to the treatment itself or partly attributable to the setting and the individual clinicians who delivered the treatment. Wide confidence intervals for some studies suggest relatively high variance within those study samples. Included clinical trials do not capture long-term effects of treatment.

5.3.2.2 BPD symptoms

Meta-analysis of seven RCTs of psychological treatments showed that, overall, psychological therapy was effective in reducing BPD symptoms, compared with treatment as usual (Table 5.2). Benefits were seen with DBT skills training (one trial²²), SFP (one trial³⁹), STEPPS (two trials^{5, 28}) and TFP (one trial³²). Neither DBT (one trial¹²) nor DDP (one trial³⁴) were associated with statistically significant benefits. However, caution is needed when interpreting these findings because of the small number of trials assessing each treatment.

Meta-analysis of nine placebo-controlled RCTs of drug treatments showed that, overall, pharmacotherapy did not significantly improve BPD symptoms (Table 5.4). Olanzapine^s (two trials^{55, 57}) and fluvoxamine^t (one trial⁴⁹) significantly improved BPD symptoms. No significant reductions in BPD symptoms were seen with lamotrigine^u (one trial²⁰⁷), phenelzine^v (two trials^{53, 208}), ziprasidone (one trial⁶⁰), or haloperidol (two trials^{53, 208}). Haloperidol (two trials^{53, 208}) was associated with an overall increase in symptoms, which was not statistically significant.

5.3.2.3 General psychopathology

Meta-analysis of 10 RCTs of psychological treatments showed that, overall, psychological therapy was effective in reducing general psychopathology, compared with treatment as usual (Table 5.2). Most studies used the Symptom Checklist-90-Revised (SCL-90-R) global severity index or the Brief Symptom Inventory (BSI) global severity index to measure psychopathology. DBT (two trials^{19, 75}), STEPPS (two trials^{5, 28}), SFP (one trial³⁹) and MBT (two trials^{11, 27}) significantly reduced general psychopathology. No significant reductions in general psychopathology were achieved with DBT skills training (one trial²²), CBT (one trial⁸), MOTR (one trial³⁶) or TFP (one trial³²). However, caution is needed when interpreting these findings because of the small number of trials for each treatment.

^s Olanzapine, ziprasidone and haloperidol are not registered in Australia for the treatment of BPD.

^t Fluvoxamine is not registered in Australia for the treatment of BPD. Registered indications include the treatment of major depression.

^u Lamotrigine is not registered in Australia for the treatment of BPD or the management of mood disorders.

^v Phenelzine is not registered in Australia for the treatment of BPD. It is indicated for major depression when other antidepressant therapy has failed.

Meta-analysis of eight placebo-controlled RCTs of drug treatments showed that, overall, pharmacotherapy significantly reduced general psychopathology. Significant benefits were seen with topiramate^w (one trial⁴⁵) aripiprazole^x (one trial⁵⁹), and olanzapine (two trials^{55, 57}). However, caution is needed when interpreting these findings because of the small number of trials for each treatment. No significant reductions in general psychopathology were seen with carbamazepine^y (one trial⁴¹), haloperidol (two trials^{53, 208}), phenelzine (two trials^{53, 208}) or ziprasidone (one trial⁶⁰).

5.3.2.4 Anger, hostility and irritability

Meta-analysis of five RCTs of psychological treatments showed that, overall, psychological therapy was effective in reducing anger in people with BPD, compared with treatment as usual (Table 5.2). Meta-analysis of four RCTs of DBT^{12, 15, 75, 195} showed that it significantly reduced anger symptoms compared with waitlist, treatment as usual or non-DBT client-centred therapy in the community. DBT skills training (one trial²²) also reduced anger, but caution is needed when interpreting this finding.

Hostility and irritability were not measured in psychological intervention studies.

Meta-analysis of placebo-controlled RCTs of drug treatments showed that, overall, pharmacotherapy significantly reduced anger, hostility and irritability in people with BPD (Table 5.4). Aripiprazole (one trial⁵⁹) significantly reduced anger and hostility. Lamotrigine (one trial⁴⁸) significantly reduced anger. Olanzapine was associated with significant reductions in hostility (one trial⁵⁷) and irritability (two trials^{55, 57}) but had no effect on anger (two trials^{55, 57}). Phenelzine (two trials^{53, 208}) significantly reduced hostility. Topiramate was associated with a significant reduction in hostility (one trial⁴⁵) but only a non-significant reduction in anger (two trials^{46, 47}). Valproate^z was associated with a significant reduction in irritability (one trial⁴³) but only a non-significant reduction in anger (two trials^{42, 43}), and had no effect on hostility (one trial⁴²). However, caution is needed when interpreting these findings because of the small number of trials assessing each treatment. Fluvoxamine and ziprasidone had no effect on anger-related outcomes.

5.3.2.5 Depression

Meta-analysis of nine RCTs of psychological treatments showed that, overall, psychological therapy was effective in reducing depression in people with BPD, compared with treatment as usual (Table 5.2). DBT (three trials^{12, 14, 15}) and DBT skills training (one trial²²) significantly reduced depression. No significant effects were seen for MBT (two trials^{11, 27}), or for CBT,⁸ STEPPS,⁵ TFP³² and DDP³⁴ (one trial each). However, caution is needed when interpreting these findings because of the small number of trials assessing each treatment.

Meta-analysis of 11 placebo-controlled RCTs of drug treatments showed that, overall, pharmacotherapy was effective in reducing depression in people with BPD (Table 5.4). However, significant reductions were only seen for valproate (two trials^{42, 43}) and aripiprazole (one trial⁵⁹). Caution is needed when interpreting these findings because of the small number of trials assessing each treatment. Haloperidol (two trials^{53, 208}) was associated with a small increase in depression.

w Topiramate is not registered in Australia for the treatment of BPD or the management of mood disorders.

x Aripiprazole is not registered in Australia for the treatment of BPD.

y Carbamazepine is not registered in Australia for the treatment of BPD.

z The preparation of valproate used in the included clinical trial was divalproex sodium. Sodium valproate is the equivalent preparation available in Australia. Sodium valproate is not registered in Australia for the treatment of BPD.

5.3.2.6 Anxiety

Meta-analysis of seven RCTs of psychological treatments showed that, overall, psychological therapy was effective in reducing anxiety in people with BPD, compared with treatment as usual (Table 5.2). DBT (three trials^{12, 15, 75}) significantly reduced anxiety. DBT skills training (one trial²²) and MBT (one trial¹¹) were also associated with significant reductions in anxiety, but caution is needed when interpreting these findings because there was only one trial for each treatment.

Meta-analysis of seven placebo-controlled RCTs of drug treatments showed that, overall, pharmacotherapy was effective in reducing anxiety in people with BPD (Table 5.4). However, only aripiprazole (one trial⁵⁹) and topiramate (one trial⁴⁵) were associated with significant reductions in anxiety. However, caution is needed when interpreting these findings because of the small number of trials assessing each treatment. Olanzapine (one trial⁵⁴) and haloperidol (one trial⁵³) were associated with non-significant increases in anxiety.

5.3.2.7 Suicidal ideation

Meta-analysis of four RCTs of psychological treatments showed that, overall, psychological therapy was effective in reducing suicidal ideation in people with BPD, compared with treatment as usual (Table 5.2). However, meta-analysis of the three DBT trials^{12, 14, 15} that measured suicidal ideation showed only a non-significant reduction.

5.3.2.8 Self-harm and suicide

Effects on self-harm and suicide should be interpreted with caution, because the outcomes measured differed between trials. Some measures may be more sensitive to change than others.

Meta-analysis of 10 RCTs of psychological treatments showed that, overall, psychological therapy was effective in reducing suicide and self-harm, compared with treatment as usual (Table 5.2). Meta-analysis of five DBT trials^{12-15, 19} showed a significant reduction in suicide and self-harm, compared with treatment as usual (including individual therapy and client-centred therapy in the community). CBT (one trial⁸), MBT (one trial²⁷) and MCT (one trial⁴) were also associated with significant reductions in suicide and self-harm. However, the findings should be interpreted with caution because there were few studies of each type and confidence intervals were wide.

Meta-analysis of four placebo-controlled RCTs of drug treatments showed that, overall, pharmacotherapy was ineffective in reducing suicidality (Table 5.4). Neither valproate^{aa} (one trial⁴³), olanzapine (two trials^{55, 57}) nor ziprasidone (one trial⁶⁰) were associated with significant reductions in suicidality when analysed separately.

5.3.2.9 General functioning

Meta-analysis of nine RCTs of psychological treatments showed that, overall, psychological therapy was effective in improving general functioning, compared with treatment as usual (Table 5.2). STEPPS (two trials^{5, 28}) and SFP (one trial³⁹) were associated with significant improvements. However, caution is needed when interpreting these findings because of the small number of trials assessing each treatment. Meta-analysis of three DBT trials^{19, 75, 195} showed a non-significant improvement, while single trials of CBT,⁸ DDP³⁴ and TFP³² each showed no significant effect on general functioning.

Meta-analysis of five placebo-controlled RCTs of drug treatments showed that, overall, pharmacotherapy was effective in improving general functioning (Table 5.4). Haloperidol (two trials^{53, 208})

aa The preparation of valproate used in the clinical trial was divalproex sodium. Sodium valproate is the equivalent preparation available in Australia. Sodium valproate is not registered in Australia for the treatment of BPD.

and olanzapine (two trials^{55, 57}) were each associated with significant improvements in general functioning. However, caution is needed when interpreting these findings because of the small number of trials assessing each treatment.

5.3.2.10 Interpersonal/social functioning

Meta-analysis of 11 RCTs of psychological treatments showed that, overall, psychological therapy was effective in improving interpersonal and social functioning, compared with treatment as usual (Table 5.2). SFP (one trial³⁹) and motive-oriented therapeutic relationship (one trial³⁶) were associated with significant improvements, but caution is needed when interpreting these findings because only a single trial assessed each treatment. No significant benefit was seen for CBT (one trial⁸), DBT (three trials^{19, 75, 195}), DBT skills training (one trial²²), DDP (one trial³⁴), MBT (two trials^{11, 27}) or STEPPS (two trials^{5, 28}).

Meta-analysis of five placebo-controlled RCTs of drug treatments showed that, overall, pharmacotherapy was effective in improving interpersonal and social functioning (Table 5.4). Aripiprazole (one trial⁵⁹) and topiramate (one trial⁵⁹) were associated with significant improvements, but caution is needed when interpreting these findings because only a single trial assessed each treatment.

5.3.2.11 Hospitalisation

Meta-analysis of five RCTs of psychological treatments showed that, overall, psychological therapy was effective in reducing hospitalisation rates, compared with treatment as usual (Table 5.2). However, only MBT (one trial²⁷) was associated with a significant reduction in hospitalisation when psychological treatment types were analysed separately.

Effects on hospitalisation rates were not reported by any of the randomised placebo-controlled clinical trials of pharmacotherapy that met inclusion criteria for meta-analysis.

5.3.2.12 Quality of life

Relatively few studies specifically measured quality of life, so meta-analysis was not undertaken. Of the studies investigating psychological treatments that included quality of life outcomes, most reported an improvement, even those that did not show significant effects on clinical measures. Most pharmacotherapy studies did not measure quality of life.

5.3.2.13 Summary of findings

The Committee determined that reliable evidence-based recommendations could not be made about the use of a particular treatment to target specific outcomes where there were fewer than three studies available for meta-analysis.

DBT was the only treatment for which three or more studies met inclusion criteria. Of the included studies, four included only women^{12, 13, 19, 75} and one included mostly women.¹⁵ DBT appeared to be effective in improving mental state, including outcome measures for anger, depression and anxiety, and in reducing self-harm in women (Table 5.2 and Appendix H). These groups may benefit particularly from a comprehensive DBT program.^{ab}

For men who self-harm, or for whom anger, anxiety or depression are significant treatment targets, evidence did not suggest that any particular psychological treatment approach was likely to be more effective than others.

ab 'Comprehensive DBT program' refers to standardised, manual-based therapy using the method developed by its originators (Linehan MM. Skills training manual for treating borderline personality disorder. New York: The Guilford Press; 1993), and delivered by one or more trained therapists.

5.3.3 Recommendations: targeting specific outcomes

	Recommendation	Grade
R18.	When reduction in self-harm is a treatment goal for women with BPD, offer a comprehensive* dialectical behaviour therapy program. *standardised, manual-based therapy using the method developed by its originators	EBR (B) ^{12, 13, 15, 19, 75}
R19.	When reduction in anger, anxiety or depression is a treatment goal for women with BPD, offer a comprehensive* dialectical behaviour therapy program. *standardised, manual-based therapy using the method developed by its originators	EBR (B) ^{12, 13, 15, 19, 75}

Evidence-based recommendation grade B: Body of evidence can be trusted to guide practice in most situations

5.4 Complementary therapies for BPD

No evidence for complementary therapies was identified.

A systematic literature search conducted for the UK national BPD clinical practice guideline¹ found no published studies that assessed the use of complementary therapies in BPD, other than omega-3 fatty acids (see Section 5.2 and Section 5.3).

Complementary therapies are frequently used by people with BPD and reported to be useful. The Committee determined that there was insufficient evidence to formulate evidence-based recommendations about the use of complementary therapies, and elected not to make consensus-based recommendations.

5.5 Delivery modes for BPD treatments

Literature was systematically searched and assessed to determine the relative effectiveness of various delivery modes (e.g. face-to-face sessions, group sessions, online programs, video) for psychological BPD treatments (clinical question 14).

The search strategy and evidence synthesis process are detailed in Appendices D to H

5.5.1 Summary of evidence: delivery modes

One level III-I study²¹⁵ was identified (Table 5.10).

The UK national BPD clinical practice guideline¹ (in the absence of a systematic evidence review) based its guidance on delivery modes used in major clinical trials of psychological therapies.

Table 5.10 Delivery modes for BPD care

Delivery mode	Summary of evidence	Level of evidence	References
Video	A US study in 30 patients with BPD compared a DBT training video (featuring DBT treatment developer, Marsha M Linehan, teaching “opposite action,” a skill from the DBT emotion-regulation module) with a control video (documentary on non-mental health topic). The DBT group showed a significant increase in knowledge of the skill, and expectations of using of the skill, compared with the control group.	III-I	Waltz, et al (2009) ²¹⁵

DBT: dialectical behaviour therapy

5.5.2 Discussion: delivery modes

Limited evidence from one study suggests that knowledge of a skill used in a specific psychological treatment for BPD could be gained through video training, but there is no evidence on clinical outcomes. There is not enough evidence to draw any conclusions about clinical outcomes of BPD treatments delivered by modes other than face-to-face (individual or group).

The Committee determined that there was insufficient evidence to formulate evidence-based recommendations on delivery modes for BPD treatments, and elected not to make consensus-based recommendations. In the absence of evidence, health professionals cannot assume that the effectiveness of psychological interventions investigated in clinical trials will be similar if the delivery mode is altered.

5.6 Multimodal treatments for BPD

Literature was systematically searched and assessed to identify studies that investigated the outcomes of multimodal therapies for BPD, compared with single-mode therapies (clinical question 10).

The search strategy and evidence synthesis process are detailed in Appendices D to H

5.6.1 Summary of evidence: multimodal treatment

Four level II studies^{30, 31, 50, 58} assessing combinations of psychological therapy and pharmacological therapy were identified (Table 5.11).

Table 5.11 Multimodal therapies versus single-mode therapies

Combinations assessed	Summary of evidence	Level of evidence	References
IPP-DBT plus fluoxetine	A randomised controlled trial compared the combination of fluoxetine and IPP with the combination of fluoxetine and clinical management (fortnightly review) in 55 patients with BPD. Both treatments improved depression and overall psychosocial functioning. BPD remission rates did not differ between groups. The IPP group showed greater improvements in anxiety, psychological functioning, interpersonal relationships, affective instability and impulsivity, compared with the clinical management group.	II	Bellino, et al (2010) ³⁰
IPP plus fluoxetine	A randomised controlled trial compared the combination of fluoxetine and IPP with the combination of fluoxetine and clinical management (fortnightly review) in 39 patients with BPD. Improvements in overall symptoms and depression did not differ between groups. The IPP group showed greater improvements in psychological functioning and social functioning, compared with the clinical management group.	II	Bellino, et al (2006) ³¹
DBT plus fluoxetine	A randomised clinical trial in 25 women with BPD compared the combination of fluoxetine plus DBT with placebo plus DBT. Fluoxetine did not provide any additional benefit to DBT.	II	Simpson, et al (2004) ⁵⁰
DBT plus olanzapine	A randomised clinical trial in 60 patients with BPD compared the combination of olanzapine plus DBT with placebo plus DBT. On intent-to-treat analysis, the olanzapine group showed greater reductions in depressive symptoms, anxiety symptoms, and aggressive/impulsive behaviour. Olanzapine was associated with weight gain and increase in blood lipid levels.	II	Soler, et al (2005) ⁵⁸

IPP: interpersonal therapy; DBT: dialectical behaviour therapy

5.6.2 Discussion: multimodal treatment

Overall, the evidence does not demonstrate that the addition of pharmacotherapy to a structured psychological intervention is more effective than the structured psychological intervention alone in the treatment of BPD.

Evidence for the role of pharmacological therapy in the management of co-occurring mental illness in people with BPD is discussed in Section 5.8.

There is not enough evidence to make evidence-based recommendations on other types of multimodal therapies versus single-mode therapies for BPD.

Some of the effective structured psychological therapies are designed as multimodal interventions within which the person receives therapy via various combinations of delivery modes such as one-to-one sessions, group sessions, telephone follow-up and planned hospitalisation (see Section 5.1).

There was insufficient evidence to enable comparison of multimodal and single-mode delivery approaches within a given psychological therapy. Although there is insufficient evidence to identify which combinations are synergistic, the Committee agreed that some people with BPD may benefit from treatment that involves combinations of:

- psychosocial and psychological interventions (e.g. psychoeducation and a structured psychological intervention)
- compatible psychological interventions (e.g. structured psychological intervention and family therapy)
- delivery modes for a single psychological therapy approach (e.g. concurrent individual therapy and group therapy).

There is insufficient evidence to determine effects of combining different structured psychological interventions that are based on conflicting theoretical constructs.

5.6.3 Recommendations: multimodal treatment

	Recommendation	Grade
R20.	Pharmacotherapy should not be routinely added to psychological interventions in the treatment of BPD.	EBR (D) ^{30, 31, 50, 58}
R21.	In addition to one-to-one psychological therapies, consider offering psychoeducation, family therapy and/or group sessions, as appropriate to the person's needs.	CBR

Evidence-based recommendation grade D: Body of evidence is weak and recommendation must be applied with caution

5.7 BPD treatment for adolescents

Literature was systematically searched and assessed to identify studies that investigated BPD treatments for adolescents (12–18 years) with BPD or features of BPD^{ac} (clinical question 5).

The search strategy and evidence synthesis process are detailed in Appendices D to H

5.7.1 Summary of evidence: BPD treatment for adolescents

The UK national BPD clinical practice guideline¹ identified one Australian randomised clinical trial⁶ comparing CAT with 'good clinical care' (standardised, structured, team-based clinical care) in people aged 14–18 years with BPD or at least two DSM-IV BPD features. The study demonstrated that both treatment approaches were effective in reducing psychopathology (compared with baseline), and neither was associated with harm. There was no statistically significant difference between treatment groups in global functioning, psychopathology, or the combination of suicide attempts and non-suicidal self-harm.

^{ac} Guidance applies to people who (a) meet diagnostic criteria for BPD or (b) show two or more DSM-IV criteria for BPD, including significant impairment in psychosocial function (see Section 4. Identifying and assessing patients with BPD).

No studies assessing pharmacological therapies in people under 18 years were identified in the UK national BPD clinical practice guideline, which based its guidance on evidence in adult populations.¹

In addition, the updated systematic review identified one level II study²⁹ and one level III-1 study⁷⁶ assessing BPD treatment in people younger than 18 years (Table 5.12).

Table 5.12 BPD treatment in adolescents: updated literature search

Treatment	Summary of evidence	Level of evidence	References
ERT	A Dutch randomised controlled trial in 43 adolescents with BPD compared a combination of ERT (a course of 17 sessions adapted from STEPPS) plus treatment as usual (medication, individual psychotherapy, system-based therapy, inpatient psychiatry care and emergency services) with treatment as usual alone (control group). Both groups showed equal reductions in BPD symptoms compared with baseline. The ERT group reported an improvement in sense of control over emotions, while the control group reported a decrease.	II	Schuppert, et al (2009) ²⁹
CAT	An Australian cohort study in 110 adolescents with either BPD or at least two DSM-IV BPD features compared CAT and 'good clinical care' (standardised, manual-based team clinical care) with treatment as usual (historical control group). Compared with the control group at two year follow-up: • both the CAT group and the 'good clinical care' group showed lower levels of psychopathology • the CAT group showed a faster improvement in psychopathology • the 'good clinical care' group showed a faster rate of recovery in global function. The CAT group showed the greatest median improvement in measures of psychopathology and psychosocial function.	III-1	Chanen, et al (2009) ⁷⁶

CAT: cognitive analytic therapy; ERT: emotion regulation training; STEPPS: systems training for emotional predictability and problem solving

5.7.2 Discussion: BPD treatment for adolescents

5.7.2.1 Evidence from treatment studies in adolescents

Structured psychosocial interventions that are specifically designed as treatments for BPD are more effective than treatment as usual in people aged 14–18 years with BPD or features of BPD. No structured intervention has been associated with worsening in outcomes over time in adolescents. The interventions shown to be effective in clinical trials shared the following characteristics:

- based on an explicit and integrated theoretical approach
- manual-based (delivered according to a standardised protocol that is specified in writing and followed by the therapist/s)
- time-limited (planned as a course of treatment over a pre-specified duration, subject to reassessment and further care planning)
- provided by a trained therapist.

While only three specific interventions (ERT, CAT and manual-based team care) have been assessed in adolescents, it is possible that other structured psychosocial BPD interventions developed for use in adults might also be effective in people under 18 years (see Section 5.1).

The efficacy of structured psychological therapy in adolescents was demonstrated in studies in which the intervention was delivered by a trained therapist. Accordingly, only appropriately trained health professionals should deliver these psychological interventions.

Two studies^{6, 76} showed benefits of structured psychological therapy in adolescents with symptoms of BPD who did not meet diagnostic criteria for BPD. The benefits of early intervention are likely to outweigh any potential adverse effects of openly discussing the provisional diagnosis of BPD, including stigma.

When developing a BPD management plan for an adolescent – as for adults – the goals of treatment should be carefully prioritised. Careful assessment is needed to identify whether the person may also need treatment for co-occurring conditions such as alcohol and other substance use disorders. The person's developmental stage should be considered and, if necessary, the management plan should accommodate episodic engagement with healthcare services.

Transitions between adolescent and adult mental health services should be carefully managed, in consultation with the young person and their family or carers.

5.7.2.2 General considerations when working with adolescents and young people with BPD

Special considerations apply when treating adolescents and young people with BPD:

- Adolescents' autonomy should be considered, while also acknowledging the responsibility of their legal guardians.
- When assessing psychopathology in adolescents, extreme distress or functional impairment should not routinely be attributed to normal adolescent behaviour. Distress and functioning should be compared with age-related peers.
- Where available and appropriate, treatment should be delivered in youth-oriented services.
- If the young person is transferred to adult services, the transition should be managed carefully to ensure the person receives continuous support.
- Health professionals should speak openly about the trajectory the young person is on with their current behaviours.¹⁸² This helps them work out how they can participate in treatment to improve their lives in future.
- Whilst it is common for adults to have developed an unhelpful relationship with health services (e.g. through the experience of actual or perceived rejection), this barrier to effective care is not typical among adolescents and young people.¹⁸²
- BPD treatment services for adolescents and young people should be available for those with clinically significant features of BPD (including significant functional impairment), who may not meet strict diagnostic criteria developed for adults.⁷⁶
- Treatment approaches for adolescents and young people should be selected as appropriate based on the person's developmental stage. The person's family should be involved in their care, as appropriate.
- It is common for adolescents and young people to attend mental health services only episodically. Although psychological treatments for BPD are designed to be delivered over a period of months to years, adolescents might only attend for shorter periods. Therefore it may be helpful to offer intermittent courses of structured psychological therapies (e.g. cognitive analytic therapy¹⁸⁹ or emotion regulation training²⁹; see Section 6.7), along with assertive case management, active engagement of families or carers (including psychoeducation), management of co-occurring conditions, pharmacotherapy when needed, and short-term goal-directed admission as necessary.¹⁸⁹

5.7.3 Recommendations: BPD treatment for adolescents

	Recommendation	Grade
R22	People aged 14–18 years with BPD or clinically significant features of BPD should be offered time-limited structured psychological therapies that are specifically designed for BPD.	EBR (B) ^{29, 76}
R23	Adolescents with BPD should be referred to structured psychological therapies that are specifically designed for this age group. Where unavailable they should be referred to youth mental health services.	PP
R24	When planning treatment for people under 18 years with BPD or clinically significant features of BPD, consider the person's developmental stage and living circumstances, and involve their family in care as appropriate.	PP
R25	For adolescents younger than 14 years with features of BPD, offer clinical psychological support and monitoring, involving their families.	PP

Evidence-based recommendation grade B: Body of evidence can be trusted to guide practice in most situations

5.8 Managing co-occurring health conditions in people with BPD

Literature was systematically searched and assessed to determine the most effective care for people with BPD who have co-occurring illness, including:

- the effectiveness of BPD treatments to reduce rates of suicide, self-harm and psychopathology, and improve psychosocial function, in people with BPD and other mental illness or chronic disease (clinical question 11)
- the effectiveness of strategies for managing co-occurring mental illness (e.g. depression, psychosis, anxiety disorders, substance use disorder and bipolar disorder^{ad}) in people with BPD (clinical question 13).

The search strategy and evidence synthesis process are detailed in Appendices D to H

5.8.1 Summary of evidence: management of co-occurring health conditions

Seven level II studies^{20, 23, 24, 34, 35, 74, 216} were identified. Co-occurring conditions included alcohol and other substance use disorders, anxiety disorders, eating disorders, and post-traumatic stress disorder (Table 5.13). No studies were identified that specifically evaluated treatment for people with BPD and a comorbid medical condition.

The UK national BPD clinical practice guideline¹ (in the absence of a systematic evidence review) based its guidance on the management of co-occurring conditions on evidence from BPD studies that included people with co-occurring conditions (including several trials assessing pharmacological treatments), consensus and guidelines for other conditions.

^{ad} The association between BPD and attention-deficit/hyperactivity disorder (ADHD) is emerging from current research. This guideline and the UK national clinical practice guideline did not specifically search for literature on interventions designed for people with BPD and co-occurring ADHD.

Table 5.13 Treatments for co-occurring health conditions in people with BPD

Co-occurring condition	Summary of evidence	Level of evidence	References
Alcohol use disorder	A RCT trial in 30 adults with BPD and alcohol use disorder compared 12 months DDP (a modified form of psychodynamic psychotherapy) with TAU (various, including individual psychotherapy, medication management and alcohol counselling, group therapy and case management). At all study follow-up points, the two groups showed no statistically significant difference in parasuicidal behaviour, alcohol misuse or institutional care. The DDP group, but not the TAU group, showed significant improvements over time on parasuicidal behaviour, alcohol misuse, and institutional care. At 30 month follow-up in 16 patients, the DDP group showed significant linear improvements over time in BPD symptoms and in depression, while the TAU group showed a modest improvement in BPD symptoms and no change in depression. The DDP group showed remission in recreational drug use, while the TAU group showed slight worsening compared with baseline. Both groups showed marked improvement in parasuicidal behaviour and improvement in alcohol use over time.	II	Gregory, et al (2008)²¹⁶ Gregory, et al (2009)³⁵ Gregory, et al (2010)³⁴
Substance use disorder	A RCT compared DFST with drug counselling for six months in 105 therapeutic community residents with a personality disorder (including 31 with BPD) and a history of substance dependence, including 29% with a current diagnosis of DSM-IV substance dependence. Among the BPD subgroup, both treatment groups showed a significant improvement in symptoms of both BPD and substance disorder during the first three months. Over the next three months the DFST group showed no further improvements, while the drug counselling group continued to improve.	II	Ball, et al (2011) ²³
Substance use disorder, anxiety disorders, eating disorders	A RCT in 101 women with BPD and recent suicidal or self-harming behaviour with comorbid Axis I disorders compared DBT with control (behavioural psychotherapy). The proportion of Axis I disorders for which patients reached full remission did not differ between treatment groups. Among patients with substance dependence disorders, the DBT group showed a significantly higher proportion of days of abstinence than the control group. There was no difference between DBT and control groups for a reduction in anxiety disorders, eating disorders, or major depressive disorder.	II	Harned, et al (2008) ²⁰
PTSD, eating disorders, substance use disorder	A double-blinded placebo-controlled crossover study investigated the use of clonidine in 17 patients with BPD and hyperarousal, of which 12 had comorbid PTSD, nine had comorbid eating disorders and seven had comorbid substance abuse. Clonidine was associated with a significant 18.3% reduction in hyperarousal overall and a 21.2% reduction in the PTSD subgroup, but no significant improvement in BPD symptoms.	II	Ziegenhorn, et al (2009) ⁷⁴

Co-occurring condition	Summary of evidence	Level of evidence	References
Eating disorder	A RCT in 134 patients with bulimia nervosa (including 38 with BPD) compared three forms of behavioural therapy following initial cognitive therapy: (i) exposure to pre-binge cues with prevention of bingeing; (ii) exposure to pre-purge cues with prevention of purging; and (iii) relaxation training. At one year follow-up, all three treatment groups showed improvements in general psychiatric functioning, with no significant difference between groups. At three year follow-up, all three treatment groups showed improvements in eating disorder symptoms. At one and three year follow-ups, outcomes did not differ between the BPD subgroup and subgroups with other personality disorders or no personality disorder.	II	Rowe, et al (2008) ²⁴

DBT: dialectical behaviour therapy; DDP: dynamic deconstructive psychotherapy; DFST: dual-focussed schema therapy; PTSD: post-traumatic stress disorder; TAU: treatment as usual

5.8.2 Discussion: management of co-occurring health conditions

5.8.2.1 Co-occurring mental illness

There is not enough evidence to demonstrate whether any specific structured psychological therapy is more effective than another for managing co-occurring mental illness in people with BPD, or for managing BPD in the presence of co-occurring mental illnesses.

The Committee determined that there was insufficient evidence to formulate evidence-based recommendations on the management of co-occurring mental illness in people with BPD. In making consensus-based recommendations, the Committee agreed on the following considerations:

- Co-occurring mental illnesses are more common among people with BPD than those without a personality disorder.²¹⁷ In particular, there are well-documented associations between BPD and depression,¹ post-traumatic stress disorder¹⁵⁵ and psychotic symptoms.²¹⁸⁻²²⁰ An association with attention-deficit/hyperactivity disorder has also been reported.^{221, 222}
- People with BPD who also meet diagnostic criteria for a substance use disorder, anxiety disorder, mood disorder or eating disorder should be offered concurrent management of both conditions. Integrated treatments for BPD and the co-occurring condition may be more appropriate than separate treatments. Most evidence-based BPD treatments have elements in common with current treatment approaches for co-occurring conditions, so an integrated approach is generally feasible.
- Available clinical trial data do not demonstrate whether treatment for substance use disorders, anxiety disorders, mood disorders or eating disorders should be altered when a person also has BPD. Nor do available clinical trial data demonstrate that BPD treatment should be altered when the person has a co-occurring condition. However, if a person's substance use is preventing BPD therapy (particularly if severe or life-threatening), this condition should be managed first.
- Various treatment approaches may have different effects on specific symptoms (see Section 5.1). However, any effective treatment for BPD might help reduce the severity of related symptoms.

5.8.2.2 Comorbid medical conditions

The Committee determined that there was insufficient evidence to formulate evidence-based recommendations on the management of comorbid medical conditions in people with BPD. In making consensus-based recommendations, the Committee agreed on the following considerations:

- People with BPD have high rates of chronic disease such as diabetes and cardiovascular disease and high rates of risk factors such as smoking. The findings of an Australian study of adolescents with BPD suggest smoking from early adolescence is common,¹⁸⁴ so chronic diseases linked to smoking may be expected to develop relatively early in people with BPD, compared with the general population.
- Rates of sexually transmitted infections are relatively high in people with BPD,^{184, 223} particularly among women with BPD and substance use disorders.²²³
- Rates of previous significant medical illness are relatively high among adolescents with BPD.¹⁸⁴
- Functional somatic symptoms are common among people with BPD. GPs and other health professionals who provide medical care for a person with BPD should assess presenting physical symptoms thoroughly (as for any other patient), while avoiding over-investigation of transient nonspecific symptoms.

5.8.3 Recommendations: management of co-occurring health conditions

	Recommendation	Grade
R26	For people with BPD who have a co-occurring mental illness (e.g. a substance use disorder, mood disorder or eating disorder), both conditions should be managed concurrently.	CBR
R27	Interventions for BPD and co-occurring mental illness should be integrated, where possible. If possible, the same therapist or treatment team should provide treatment for both conditions. Where this is not possible, the health service or therapist providing treatment for the co-occurring condition should collaborate with the person's main clinician who is responsible for managing their BPD.	CBR
R28	If a person's substance use is severe, life-threatening or interfering with BPD therapy, health professionals should actively work to engage the person in effective BPD treatment, but give priority in the first instance to the stabilisation of their substance use disorder to allow effective BPD treatment. Treatment should focus on managing the substance use disorder before effective BPD treatment can continue.	CBR
R29	Medical symptoms in people with BPD should be thoroughly assessed and managed effectively by a GP or appropriate specialist.	CBR
R30	GPs should provide advice and follow-up (e.g. reminders) to encourage people with BPD to participate in screening and preventive health measures, such as cervical cancer screening for women.	PP

5.9 Managing complex and severe BPD

The Committee determined not to conduct a literature search to identify studies that investigated treatment for people with ‘complex and severe’^{ae} BPD (clinical question 12), based on the following considerations:

- There is no standard definition of complex and severe BPD that is used in clinical trials. Indices that have been used to describe severity include the Borderline Personality Disorder Severity Index²²⁴ and the Zanarini Rating Scale for Borderline Personality Disorder.²²⁵ However, intervention trials have not consistently and routinely applied these during sample selection.
- An operational definition of ‘complex and severe’ cases (e.g. based on the number of self-harm episodes, suicide attempts, or co-occurring conditions) is unlikely to be reliable for identifying relevant studies, because the characteristics of study samples are often not described in sufficient detail to allow the required data to be extracted.
- In clinical practice, complex and severe cases are usually defined as those that require higher use of services and more complex interventions, such as specialised services. Accordingly, an attempt to determine the most effective treatment strategies in this group would be confounded by the problem of circular definition.

5.9.1 Discussion: complex and severe BPD

By definition, BPD is a complex illness because it is a syndrome of multiple symptoms and pathologies. A person’s level of function is not determined by objectively defined underlying disease severity.

Access to specific treatments or healthcare delivery modes should not be limited according to functional level, because an individual’s mental suffering is not necessarily reflected in the degree of overt disability. Rather, healthcare needs for people with BPD are properly determined by individual needs.

‘Complex and severe personality disorder’ (CSPD) was recently defined by a UK working party, for the purpose of developing national public health policy and service commissioning protocols.²²⁶ People with CSPD are characterised as being vulnerable at all times, experiencing only short periods of normal functioning, experiencing significant disruption to their lives triggered by relatively minor stressors, and being continuously at risk of self-harm, self-neglect or harm due to impulsive behaviour, but not posing significant risk of harm to others. These people typically have dysfunctional families and are likely to be involved in the criminal justice system. People with CSPD were identified as those for whom treatment within community-based personality disorder services may not be sufficient.

The Committee determined not to make specific recommendations for the care of people with complex and severe BPD according to pre-defined features.

^{ae} In the UK national clinical practice guideline for the treatment and management of BPD, the term “complex and severe BPD” reflected the structure of the UK National Health Service, in which defined tiers of service delivery are specified based on health condition, including severity.

5.10 Cost-effectiveness of BPD treatments

Literature was systematically searched to identify studies that assessed the cost-effectiveness of BPD treatments.

The search strategy and evidence synthesis process are detailed in Appendices D to H

5.10.1 Summary of evidence: cost-effectiveness

The UK national BPD clinical practice guideline¹ identified seven studies that assessed the cost-effectiveness of psychological treatments and treatment programs based on psychological approaches including CBT,²²⁷ schema-focussed psychotherapy,²²⁸ transference-focussed psychotherapy,²²⁸ psychodynamic interpersonal therapy (The Conversational Model),²²⁹ mentalisation-based therapy,²³⁰ DBT²³¹ and therapeutic communities.^{232, 233}

In addition, the updated systematic review identified one level II study²³⁴ (Table 5.14).

Table 5.14 Risk factors for BPD: updated literature search

Intervention	Summary of evidence	Level of evidence	Reference
DBT (Australia)	A RCT compared outpatient DBT with treatment as usual (clinical case management) in 91 people with BPD attending a public mental health service. DBT was more cost-effective than TAU.	II	Pasieczny, et al (2011) ²³⁴

DBT: dialectical behaviour therapy; TAU: treatment as usual

5.10.2 Discussion: cost-effectiveness

Evidence on the cost-effectiveness of psychological therapies in the treatment of people with BPD was limited, inconsistent and not generally applicable to the Australian healthcare system.

A 2006 systematic review of psychological therapies for BPD²³¹ suggested DBT was potentially cost-effective, but the review had methodological limitations.²³¹ Australian studies reported that DBT was more cost-effective than treatment as usual,²³⁴ and that psychodynamic interpersonal therapy (The Conversational Model) resulted in savings in healthcare costs compared with pre-therapy healthcare usage, particularly among recipients who were heavy users of healthcare services.²²⁹ Data from a UK clinical trial suggested that MBT with partial hospitalisation was potentially more cost-effective than treatment as usual, based on limited cost data.²³⁰

A UK clinical trial including cost-effectiveness measures found that CBT was unlikely to be more cost effective than other treatments in people with BPD.²²⁷ Data from a Dutch multicentre clinical trial suggest that SFP was less costly than TFP over 4 years.²²⁸ Studies assessing cost-effectiveness of therapeutic communities^{232, 233} were of limited quality and application to the Australian health-care system.

No evidence on the cost-effectiveness of pharmacological treatments for people with BPD was identified.

The Committee determined that there was insufficient evidence to formulate evidence-based recommendations on the cost-effectiveness of treatments for BPD, and elected not to make consensus-based recommendations.

5.11 Clinical and resource implications for recommendations 8–30: managing BPD

5.11.1 Clinical implications of the recommendations

The guideline emphasises the use of structured psychological treatments for people with BPD (recommendations 8–10), including adolescents (recommendations 22–25), subgroups with specific treatment needs (recommendations 19–20), and people with co-occurring mental health or medical conditions (recommendations 26–30).

Current treatment for people with BPD in Australia varies considerably, and for some people involves styles of therapy that are relatively unstructured or lack a foreseeable end point. In contrast, this guideline recommends therapies that are manual-based, standardised and structured. Uptake of these recommendations would be expected to significantly improve the care of people with BPD. However, these recommendations may not be aligned with current practice of some mental health professionals. Tailored implementation strategies may be necessary to promote acceptance and adoption of these recommendations.

Where youth-specific or BPD-specific services are not offered (recommendations 22–23), health professionals may need to undertake additional training about assessment, diagnosis, and management of BPD in adolescents.

The recommendations that mental health professionals consider dialectal behavioural therapy (DBT) for women with BPD for whom reduction in self-harm, anger, anxiety or depression are treatment goals (recommendations 18–19) may not be readily implemented by health professionals who do not practise this therapy or in areas where there are no DBT programs. While the recommendation is based on the fact that there is objectively more current evidence for DBT than other treatments in the specified subpopulation, overall evidence suggests that any structured, manualised approach is superior to treatment as usual (unstructured therapy).

The recommendations for the care of people with co-occurring medical conditions and for routine preventive medicine in people with BPD (recommendations 29–30) are directed mainly to primary care health professionals. Implementation of these would reduce risk of common chronic illness among people with BPD so that, as they recover from BPD, they may enjoy healthy middle and late adulthood.

The guideline recommends against the use of medicines as the main treatment for a person with BPD and describes a limited and specific role for medicines (recommendations 11–17 and 21). In current medical practice, many people with BPD are prescribed medicines that are unnecessary or may have adverse effects. The series of recommendations cautioning the use of medicines would be expected to reduce inappropriate prescribing, reduce the risk of misuse of prescribed medicines, and reduce distress associated with adverse effects of prescribed medicines. However, these recommendations may contradict current practices and might require appropriate implementation strategies aimed at re-educating prescribers.

5.11.2 Resource implications of the recommendations

There is currently a shortage of private and public community-based psychiatric services to which health professionals can refer patients for assessment. Implementation of the recommendations for structured psychological treatments for people with BPD (recommendations 8–10, 18–19, 21–28) will increase demand for these therapies and programs and is likely to exceed current capacity.

The recommendations that mental health professionals consider dialectical behavioural therapy (DBT) for women with BPD for whom reduction in self-harm, anger, anxiety or depression are treatment goals (recommendations 18–19) might influence service planning, funding and coordination of health services where DBT is not currently offered. However, it may not be necessary to retrain therapists in a particular type of therapy, given that any structured, manualised approach is superior to treatment as usual (unstructured therapy). Therefore, the main demand on resources will be providing access to structured psychological therapies throughout Australia, rather than focussing on training therapists in one approach.

It is common for multiple medicines to be prescribed for a person with BPD and withdrawn sequentially or simultaneously over a short period, resulting in scripts being filled but not used. Therefore, the recommendations for limited use of medicines for people with BPD (recommendations 11–17 and 21) may be expected to result in reduced wastage of psychotropic agents subsidised by the Pharmaceutical Benefits Scheme.

6. Organising healthcare services to meet the needs of people with BPD

6.1 Effectiveness and safety of BPD treatment delivered by different types of healthcare services

Literature was systematically searched and assessed to identify the types of healthcare services (e.g. primary care, acute care, inpatient services, team-based or individual-based care) that deliver BPD treatments most effectively and safely, taking into account long-term outcomes (clinical question 15).

The search strategy and evidence synthesis process are detailed in Appendices D to H

6.1.1 Summary of evidence: who should offer BPD treatment?

Two level III-2 studies^{77, 235} were identified, neither of which were directly applicable to the Australian healthcare setting (Table 6.1).

No other evidence was identified by the UK national BPD clinical practice guideline.¹

Table 6.1 Effectiveness and safety of BPD treatment according to type of healthcare service

Service type	Summary of evidence	Level of evidence	References
Inpatient admission to a general hospital (Switzerland)	A prospective cohort study compared (i) crisis intervention (intensive individual psychotherapy during five day admission, family therapy and support) with (ii) treatment as usual (clinical judgement of psychiatrist), in 200 patients with BPD and self-harm following presentation to the emergency department. Both treatment and control groups showed high rates of suicide attempts and concurrent major depression. At three months follow-up, the intervention group (versus control group) showed a lower rate of psychiatric hospitalisation (5% versus 56%), a lower rate of suicide attempts (8% versus 17%), longer mean time to relapse of self-harm/suicide after a suicide attempt (85.6 days versus 79.8 days), longer time to rehospitalisation (81.1 days versus 42.2 days), and shorter mean hospital admission (1.94 versus 9.3 days).	III-2	Berrino, et al (2011) ⁷⁷

Service type	Summary of evidence	Level of evidence	References
Inpatient, outpatient and day hospital (The Netherlands)	A nonrandomised multicentre clinical trial compared (i) individual psychotherapy in outpatient setting of mean 14.5 months duration, (ii) a day hospital program of mean 10.4 months duration, and (iii) an inpatient program of individual and group therapy of mean duration 9.1 months, in 207 patients with personality disorders (77% BPD). At 18 months follow-up, all groups showed improvements in psychiatric symptoms, psychosocial functioning and quality of life. Improvements were numerically higher (no statistically significant difference) in inpatient group.	III-2	Bartak, et al (2011) ²³⁵

6.1.2 Discussion: who should offer BPD treatment?

The Committee determined that there was insufficient evidence to formulate evidence-based recommendations on the types of services that can deliver BPD treatments most effectively and safely and on the roles of healthcare services in providing BPD treatment. In making consensus-based recommendations, the Committee agreed on the following considerations:

- Care is most likely to be effective when tailored to the individual's needs and guided by a well-documented management plan. Effective and safe treatment for BPD can be given in a variety of service settings, including primary care (general practice, Aboriginal medical services, community health), public community mental health services (including child and adolescent mental health services, adult mental health services and aged mental health services), public and private hospital outpatient psychiatry departments, inpatient psychiatric facilities, private office-based psychiatry practices, specialised BPD programs and services, accident and emergency services, and combinations of services (e.g. through structured private/public collaborations).
- The majority of a person's treatment for BPD should be provided within the community, because recovery is best supported when the person is encouraged to be a functioning member of the community.²³⁶ Most effective psychological therapies for BPD were originally developed within community settings (such as private practice or clinics attached to teaching hospitals), although some have been adapted for inpatient settings. Brief inpatient stays and specialised residential programs can be incorporated into an individual's management plan, as indicated.
- Admission to an inpatient facility may be indicated to manage acute crises such as serious self-harm or suicidal behaviour (see Section 6.3). However, evidence from clinical studies does not demonstrate that inpatient care is effective in preventing suicide. Admission to an inpatient facility may be appropriate for people who have benefited in the past. Prolonged admission should be avoided (see Section 6.4).
- People with BPD should have access to the type of service best suited to their needs. Consumers have expressed a demand for a choice of services for BPD treatment.

6.1.3 Recommendations: who should offer BPD treatment?

	Recommendation	Grade
R31.	The majority of a person's treatment for BPD should be provided by community-based mental health services (public and private).	CBR
R32.	BPD treatments should be offered through a range of services, as appropriate to the individual's current clinical presentation, course of illness, needs and (if applicable) preferences.	CBR

6.2 Effectiveness of treatments according to service type

Literature was systematically searched and assessed to identify whether specific BPD treatments are more or less effective when delivered by particular service settings (clinical question 19).

The search strategy and evidence synthesis process are detailed in Appendices D to H

6.2.1 Summary of evidence: which BPD treatments to offer according to service type

No studies were identified.

6.2.2 Discussion: which BPD treatments to offer according to service type

The Committee determined that there was insufficient evidence to formulate evidence-based recommendations on the efficacy of specific BPD therapies to be delivered by particular types of healthcare services, and elected not to make consensus-based recommendations.

6.3 Role of acute inpatient care

Literature was systematically searched and assessed to identify the effectiveness and efficacy of acute inpatient care in the treatment of people with BPD (clinical question 16).

The search strategy and evidence synthesis process are detailed in Appendices D to H

6.3.1 Summary of evidence: acute inpatient care

One level III-2 study⁷⁷ assessed the effectiveness of crisis intervention consisting of intensive individual psychotherapy delivered during a five day hospital admission following presentation to emergency department, together with family therapy and support (Table 6.2).

No other evidence was identified in the UK national BPD clinical practice guideline.¹

Table 6.2 Role of acute inpatient care for BPD

Role evaluated	Summary of evidence	Level of evidence	References
Delivery of short crisis intervention following presentation to emergency department (Switzerland)	A prospective cohort study compared (i) crisis intervention (intensive individual psychotherapy during five day admission, family therapy and support) with (ii) treatment as usual (clinical judgement of psychiatrist), in 200 patients with BPD and self-harm following presentation to emergency department. Both treatment and control groups showed high rates of suicide attempts and concurrent major depression. At three months follow-up, the intervention group (versus control group) showed a lower rate of psychiatric hospitalisation (5% versus 56%), a lower rate of suicide attempts (8% versus 17%), longer mean time to relapse of self-harm/suicide after a suicide attempt (85.6 days versus 79.8 days), longer time to rehospitalisation (81.1 days versus 42.2 days), and shorter mean hospital admission (1.94 versus 9.3 days).	III-2	Berrino, et al (2011) ⁷⁷

6.3.2 Discussion: acute inpatient care

While the findings of Berrino, et al (2011)⁷⁷ and evidence assessed in the UK national BPD clinical practice guideline¹ had only limited application to Australian healthcare settings, they suggested that acute inpatient admission to provide structured crisis intervention may benefit people who are suicidal or have significant co-occurring psychiatric conditions such as major depression and self-harm.

The Committee also considered clinical experience and expert opinion in formulating a consensus-based recommendation on the role of inpatient care for people with BPD.

There is general consensus in international literature that, if people with BPD need admission to a non-specialist inpatient psychiatric unit (e.g. during a crisis), then the stay should be brief and treatment should focus on dealing with the crisis.¹

Overall, available evidence and expert opinion suggest that inpatient care should be reserved for short-term crisis intervention for people at high risk of suicide or medically serious self-harm. It should be directed towards achieving specific goals that are agreed before admission.

6.3.3 Recommendations: acute inpatient care

	Recommendation	Grade
R33.	Acute inpatient admission to provide structured crisis intervention could be considered for the treatment of people who are suicidal or have significant co-occurring mental health conditions.	EBR (C) ⁷⁷
R34.	Inpatient care should be reserved for short-term crisis intervention for people at high risk of suicide or medically serious self-harm. Where used, inpatient care should be: • brief (except for specialised structured residential services that provide intensive interventions) • directed towards specific, pre-identified goals.	CBR

Evidence-based recommendation grade C: Body of evidence provides some support for recommendation(s) but care should be taken in its application

6.4 Role of long-term inpatient care

Literature was systematically searched and assessed to identify the effectiveness and efficacy of long-term inpatient care in the treatment of people with BPD (clinical question 18).

The search strategy and evidence synthesis process are detailed in Appendices D to H

6.4.1 Summary of evidence: long-term inpatient care

One level III-2 study²³⁵ was identified (Table 6.3).

No other evidence that met the inclusion criteria for this guideline was identified in the UK national BPD clinical practice guideline.¹

Table 6.3 Effectiveness of long-term inpatient care for BPD

Type of inpatient care	Summary of evidence	Level of evidence	References
Mental health care centre admission (The Netherlands)	A nonrandomised multicentre clinical trial compared (i) individual psychotherapy in outpatient setting of mean 14.5 months duration, (ii) a day hospital program of mean 10.4 months duration, and (iii) an inpatient program of individual and group therapy of mean duration 9.1 months, in 207 patients with personality disorders (77% BPD). At 18 months follow-up, all groups showed improvements in psychiatric symptoms, psychosocial functioning and quality of life. Improvements were numerically higher (no statistically significant difference) in inpatient group.	III-2	Bartak, et al (2011) ²³⁵

6.4.2 Discussion: long-term inpatient care

The Committee determined that there was insufficient evidence to formulate evidence-based recommendations on the role of long-term inpatient care. In making consensus-based recommendations, the Committee agreed on the following considerations:

- Australian healthcare policy does not support the maintenance of intensive psychotherapy units in public hospitals. Therefore, overseas evidence may not apply to the Australian setting.
- There is general consensus in clinical literature that prolonged admission to a standard psychiatric inpatient service is ineffective in the treatment of people with BPD.¹ Some experts have argued that inpatient admission for people with BPD is actually detrimental. However, the UK national BPD clinical practice guideline found no evidence that long-term hospitalisation was either effective or harmful for people with BPD.¹
- In rare circumstances, long-term inpatient care may be indicated when other options are unsuitable for an individual (e.g. a homeless pregnant woman). Some people may benefit from longer-term care within a structured residential service designed specifically for people with BPD.
- Potential risks of inpatient care for a person with BPD, such as loss of independence, might be minimised by encouraging the person to share responsibility for the decision to be admitted, ensuring that the person understands the potential benefits and harms of admission, and agreeing with the person about the purpose and length of the admission in advance.¹

6.4.3 Recommendations: long-term inpatient care

	Recommendation	Grade
R35.	Long-term inpatient care for people with BPD should generally be avoided, except in the context of specialised BPD services.	CBR
R36.	When considering inpatient care for a person with BPD, health professionals should involve the person (and family, partner or carers, if possible) in the decision, and ensure the decision is based on an explicit, joint understanding of the potential benefits and likely harm that may result from admission, and agree on the length and purpose of the admission in advance.	PP

6.5 Role of specialised BPD services

Literature was systematically searched and assessed to identify the effectiveness and efficacy of specialised services for people with BPD (including community-based and inpatient services) in medium- and long-term care (clinical question 17).

The search strategy and evidence synthesis process are detailed in Appendices D to H

6.5.1 Summary of evidence: specialised BPD services

No studies were identified.

6.5.2 Discussion: specialised BPD services

The Committee determined that there was insufficient evidence to formulate evidence-based recommendations on the role of specialised BPD services. In making consensus-based recommendations, the Committee agreed on the following considerations:

- Referral to a specialised BPD service is not routinely indicated for all people with BPD. People with complex care needs may benefit from treatment within a specialised BPD service.
- For most people with BPD, effective treatment with a structured psychological therapy can be provided within mainstream public or private community-based mental health services, via individual appointments (with or without group sessions), by therapists with access to peer consultation and clinical review.
- The roles of specialised BPD services include:
 - treatment of people with complex care needs or those at high risk for suicide or significant self-harm
 - providing consultation to primary care services and mental health services
 - education, training, supervision and support for health professionals, including support for rural and remote services, education for local general mental health services, and consultation and advice for GPs managing BPD
 - health promotion and advocacy (e.g. raising awareness of BPD and reducing stigma)
 - providing education for families and carers and supporting them
 - undertaking research to develop better treatment models.

6.5.3 Recommendations: specialised BPD services

	Recommendation	Grade
R37.	Health professionals should consider referring people with severe and/or enduring BPD to a suitable specialised BPD service (where available) for assessment and ongoing care, if appropriate.	CBR

6.6 Roles of various health professionals in BPD care

Literature was systematically searched and assessed to identify the appropriate roles of health professionals from various healthcare services (e.g. primary care, accident and emergency services, acute care, drug and alcohol services, eating disorder services, crisis accommodation services) in caring for people with BPD (clinical question 20).

6.6.1 Summary of evidence: health professionals' roles in BPD treatment

No studies were identified.

6.6.2 Discussion: health professionals' roles in BPD treatment

The Committee determined that there was insufficient evidence to formulate evidence-based recommendations on the roles of health professionals in the care of people with BPD, other than those directly involved in providing specific BPD treatments. In making consensus-based recommendations, the Committee agreed on the following considerations:

- All health professionals can provide or support effective care for people with BPD and avoid harm by:
 - being able to recognise features of BPD
 - understanding the specific needs of people with BPD (see Chapter 8)
 - participating in risk assessment and management, as appropriate to the type of service they can provide
 - establishing referral links agreed referral protocols with local services, and referring clients with BPD to appropriate providers as indicated
 - supporting and working effectively with family members, partners and carers.
- The general principles of working with people with BPD (see Chapter 8) apply to all health professionals.

6.6.2.1 General practice

General practice (including GPs, practice nurses, nurse practitioners, Aboriginal health workers, and mental health professionals such as clinical psychologists) plays a major role in the health care of people with BPD. GPs can contribute to prompt diagnosis and treatment for people with BPD by conducting mental health assessment for any person who has repeatedly self-harmed, shown persistent risk-taking behaviour or shown marked emotional instability. GPs should consider referring the person to mental health services for diagnostic assessment if the diagnosis is uncertain.

Referral to mental health services is not necessarily indicated for isolated crises.

When the diagnosis of BPD has been made, GPs can provide or support effective BPD treatment by:

- ensuring that other health professionals within the service are aware of the general principles of caring for a person with BPD (see Chapter 8)
- working with the person to develop a BPD management plan (see Section 8.4), or obtaining and reviewing the management plan if this has been developed by the person's main clinician within another service. The management plan should include a plan for accessing care during a crisis (e.g. if the person has life-threatening self-injury, they should be encouraged to attend an emergency department first)
- referring the person to an appropriate mental health service for specific treatment when indicated, and collaborating as part of the mental healthcare team, to ensure that treatment is consistent and cohesive
- treating the person for co-occurring mental illness such as depression. Prescribers should avoid inappropriate strategies such as polypharmacy, which is likely to be ineffective and may cause harm¹ (refer to principles of rational prescribing in people with BPD in Section 5.2)
- providing structured psychological therapies such as general psychiatric management, if they have appropriate training and skills.

Some people with BPD have contact with multiple services. Before referring the person to another service, GPs should consider the support that is already being provided.¹ Referral to mental health services should be considered if the person has complex care needs or severe BPD, if clinically significant symptoms do not improve over time, if the person is at risk of suicide or self-harm, or if their behaviour is a risk to other people.

GPs should discuss their role with the person, clearly explaining the type of health care they can provide (e.g. general medical care, treatment for co-occurring mental health conditions, case coordination, assessment of pharmacotherapy, or a combination of these). The GP should ensure that other staff (e.g. practice managers, reception staff) are aware of agreements with the person about their access to care, and are trained to interact with the person appropriately (e.g. show courtesy, provide reliable information, and maintain agreed protocols).

When providing general medical care, primary care staff should avoid in-depth discussion of issues related to childhood, relationships or other life situations, but should suggest that these issues may be best discussed with their main clinician (if they are receiving BPD treatment from a mental health professional).¹⁸²

If a person with BPD presents to primary care during a mental health crisis, staff should follow the person's BPD management plan or crisis management plan. An appropriate response includes:

- assessing current risk to self and others
- asking about crisis management strategies that have helped in the past
- helping the person manage their anxiety
- encouraging the person to identify practical actions that will help them deal with current problems
- offering a follow-up appointment.

Referral to a mental health service should be considered if the person's distress is increasing or there is risk that they will harm themselves or other people.

6.6.2.2 Emergency services

Emergency service staff can contribute to prompt diagnosis and treatment for people with BPD by arranging mental health assessment for people who have repeatedly self-harmed.

Emergency service managers should establish protocols to ensure that people with known BPD are recognised, receive care promptly and are treated in a non-judgemental way that will not worsen their symptoms or escalate a crisis (see Section 8.5).

When a person with BPD presents to emergency services following suicidal behaviour or self-harm, staff should follow the principles of managing self-harm and suicide risk in people with BPD described in Section 8.5.

Initiate mental health treatment while medical needs are being dealt with. Staff can help avoid reinforcing self-harming behaviours by attending to self-inflicted injuries professionally and compassionately.

Risk assessment should be conducted to determine whether the person requires admission to a psychiatric unit. Once the person is stabilised, staff should determine whether the person is receiving long-term psychological treatment and arrange referrals as necessary. At discharge, the person's GP and mental healthcare provider/s should be contacted.

For people with BPD who repeatedly present to emergency departments, treatment providers should establish a crisis management plan that explicitly outlines the person's assessment and management in the emergency department, in addition to an overarching management plan. These plans should be developed in active liaison with the emergency department.

6.6.2.3 Crisis teams

Staff of community-based crisis response teams (e.g. Enhanced Crisis Assessment Treatment Teams, Crisis Assessment and Treatment Teams, Mental Health Triage Services, Assessment and Crisis Intervention Services, Community Acute Care Teams) can provide effective care for people with BPD using the principles of crisis management set out in Table 8.5.

6.6.3 Recommendations: health professionals' roles in BPD treatment

	Recommendation	Grade
R38.	Health professionals at all levels of the healthcare system and within each type of service setting should: • acknowledge that BPD treatment is a legitimate use of healthcare services • be able to recognise BPD presentations • be aware of general principles of care for people with BPD and specific effective BPD treatments • provide appropriate care (including non-specific mental health management, specific treatments for BPD and treatment for co-occurring mental illness) according to their level of training and skill • refer the person to a specialised BPD service or other services as indicated • undertake continuing professional development to maintain and enhance their skills.	CBR

6.7 Coordinating care for people with BPD

Literature was systematically searched and assessed to identify treatment pathways (e.g. referral pathways, coordination between services, or systems for matching individual needs to treatment) that maximise the effectiveness of care for people with BPD and reduce harm (clinical question 21).

The search strategy and evidence synthesis process are detailed in Appendices D to H

6.7.1 Summary of evidence: coordinating care

No studies were identified.

6.7.2 Discussion: coordinating care

The Committee determined that there was insufficient evidence to formulate evidence-based recommendations on coordinating care for people with BPD. In making consensus-based recommendations, the Committee agreed on the following considerations:

- Coordination and collaboration between all health professionals treating the person is important for all areas of health care. For people with BPD it is crucial for effective care and to minimise harm.
- ‘Stepped care’ approaches have been advocated to overcome the problem of poor access to psychological therapy services due to the limited availability of trained therapists.²³⁷ A stepped-care approach involves beginning with the least intensive treatment that is likely to be effective, then monitoring response to increase or reduce the intensity of the intervention according to the person’s needs. Within this approach, more intensive treatments are generally reserved for people who do not benefit from simpler first-line treatments, or for those who can be accurately predicted not to benefit from such treatments.²³⁷ Stepped care has been recommended for people with BPD.¹⁹⁷ There is limited evidence that stepped care might be an efficient method of delivering psychological services but more research is needed,²³⁷ including evidence in BPD populations.
- Some people have complex care needs and will require treatment by multiple health professionals (multidisciplinary care). Each health professional providing care for a person with BPD should take responsibility for effective teamwork, collaboration, communication and coordination. If more than one service is involved in an individual’s care, services should agree on one provider as the person’s main contact (main clinician). The main clinician can be a therapist or case manager, GP, psychiatrist or psychologist. The main clinician should take responsibility for coordinating care provided by other services, as indicated by the person’s current symptoms and needs. All health professionals treating people with BPD should make sure they know who is the person’s main clinician.
- Only one health professional should be responsible for prescribing medicines. Sometimes it may be appropriate for providers to make an agreement with the person that nominated services such as the general practice will not supply psychotropic medicines.
- Some mental health professionals have promoted a coordinated approach involving a case manager, a psychotherapist and other providers as necessary, in which the person has the opportunity to discuss treatment-related problems or frustrations with any of the providers during planned reviews,¹⁹⁷ with the aim of avoiding the situation in which the person quits therapy and loses contact prematurely. For example, the case manager can discuss problems and encourage the person to raise these with the psychotherapist.²³⁸

- Health system planners should ensure that people have access to healthcare services appropriate to their needs within their local area or as close as possible.
- Where more than one treatment option or service setting is suitable for an individual's clinical needs, health professionals should explain the options and support the person to choose.
- Services that treat people with BPD should provide support and education for families/carers, or direct them to appropriate support services.

6.7.3 Recommendations: coordinating care

	Recommendation	Grade
R39.	Clinicians treating people with BPD should follow a stepped-care approach in which an individual's usual care is based on the least intensive treatment (such as general practice care and regular contact with a community mental health service), and referral to more intensive treatment (such as crisis intervention, a specialised BPD service, or specialised BPD programs) is provided when indicated.	CBR
R40.	Health professionals within each type of service should set up links with other services to facilitate referral and collaboration.	CBR
R41.	Managers and health system planners should configure services to ensure that people can access more intensive treatment options, such as a specialised BPD service, when needed.	CBR
R42.	If more than one service is involved in an individual's care, services should agree on one provider as the person's main contact (main clinician), who is responsible for coordinating care across services.	CBR
R43.	All health professionals treating people with BPD should make sure they know who the person's main clinician is.	CBR
R44.	Health system planners should ensure that people have access to healthcare services appropriate to their needs within their local area or as close as possible.	CBR
R45.	Where more than one treatment option or service setting is suitable for an individual's clinical needs, health professionals should explain the options and support the person to choose.	CBR

6.8 Supporting health professionals who care for people with BPD

Literature was systematically searched and assessed to identify the most effective ways to support healthcare professionals involved in the care of people with BPD, through means such as appropriate supervision, training and optimal caseloads (clinical question 22).

The search strategy and evidence synthesis process are detailed in Appendices D to H

6.8.1 Summary of evidence: supporting healthcare professionals

Two level II studies^{239, 240} were identified (Table 6.4).

No other evidence was identified in the UK national BPD clinical practice guideline.¹

Table 6.4 Supporting healthcare professionals for BPD care

Support type	Summary of evidence	Level of evidence	References
Training in DBT	A RCT assessed knowledge, skills, self-efficacy, and motivation to apply DBT skills among 132 mental health or drug treatment health professionals and trainees (currently treating clients with drug use or suicidality) after completing either (i) a DBT training manual, (ii) electronic version of DBT training manual (eDBT) or (iii) a 'placebo' electronic learning program (control group). DBT training groups performed better than the control group on all outcomes except motivation to learn and use the treatment. At 15 weeks follow-up, the eDBT group showed greater knowledge and used the skills more than those who used the standard training manual.	II	Dimeff, et al (2011) ²³⁹
Training in CBT or psychoanalytic training	A RCT compared attitudes to self-harm by patients with BPD in 140 health professionals working in mental health or emergency services after either (i) CBT training, (ii) psychoanalytic training, or (iii) no training (control group). Compared with the control group, both training groups showed a significant improvement in attitudes (deliberate Self-Harm Questionnaire) immediately after training. At six months follow-up, the psychoanalytic training group, but not the CBT training group, maintained a significant improvement in attitudes.	II	Commons Treloar, et al (2009) ²⁴⁰

DBT: dialectical behaviour therapy; CBT: cognitive-behavioural therapy

6.8.2 Discussion: supporting healthcare professionals

The Committee determined that there was some evidence that training can change health professionals' attitudes toward people with BPD,^{239, 240} but insufficient evidence to recommend specific training programs.

The Committee determined that there was insufficient evidence to formulate evidence-based recommendations on components of support or specific caseloads for health professionals working with people with BPD. In making consensus-based recommendations, the Committee agreed on the following considerations:

- The effectiveness of a psychological intervention in clinical practice is likely to depend on therapists having the skills and the organisational support to replicate the intervention found effective in research settings.¹
- Those responsible for planning or managing services that provide treatment for people with BPD should ensure that health professionals receive adequate training in the recognition, assessment and management of BPD. For group practices or services with several health professionals, training should involve all staff within a service, using a group learning approach.
- Training in how to recognise BPD and care for people with BPD should be incorporated into undergraduate medical and nursing education, and into postgraduate training for all health professional disciplines likely to be involved in the care of people with BPD, including GPs, emergency physicians, clinical psychologists and physicians. Medical education for all of these groups should be designed to counter prevailing negative attitudes of health professionals towards people with BPD, and should emphasise that all health professionals can contribute to effective care for people with BPD.

- Service managers and team leaders are responsible for ensuring that caseloads for clinicians who treat people with BPD are appropriate and realistic according to the clinician's experience, the needs of individuals according to phase of treatment, the requirements of the specific treatments provided, and the number of complex cases.
- Those responsible for planning or managing services that provide psychological BPD treatments should ensure that health professionals receive adequate supervision according to their caseload. Intense supervision is needed for those mainly or exclusively working with people with BPD, while supervision may be less intense for those treating BPD irregularly (e.g. emergency department staff, those seeing BPD occasionally or as a low proportion of caseload).
- Health professionals who provide psychological therapies for people with BPD can experience emotional reactions that are potentially unhealthy for themselves, their clients and other team members, and can disrupt effective teamwork.²⁴¹ Strategies to contain unhelpful effects of emotional responses can include effective leadership within the team and the service, a clear agreement on each team member's roles and responsibilities, regular case discussion meetings, and the practice of continually referring to the agreed BPD management plan to consolidate team goals, agreed treatment strategies and their rationale.²⁴¹
- Those responsible for planning or managing services that provide care for people with BPD should ensure that health professionals receive appropriate support, including participation in a structured peer support program and access to secondary consultation provided by an experienced expert in BPD care.

6.8.3 Recommendations: supporting healthcare professionals

	Recommendation	Grade
R46.	Those responsible for planning or managing services that provide care for people with BPD should ensure that health professionals receive training in BPD management.	CBR
R47.	For group practices or services with several health professionals, training should involve all staff within a service, using a group learning approach.	CBR
R48.	Service managers should ensure that caseloads for clinicians who treat people with BPD are appropriate and realistic according to: • their experience • the needs of individuals according to phase of treatment • the requirements of the specific treatments provided • the number of complex cases.	CBR
R49.	Those responsible for planning or managing services that provide care for people with BPD should ensure that health professionals receive adequate supervision according to their level of experience and BPD caseload (taking into account case complexity).	CBR
R50.	Those responsible for planning or managing services that provide care for people with BPD should ensure that health professionals receive appropriate support, including: • participation in a structured peer support program • access to secondary consultation provided by an expert in BPD care or specialised BPD service.	CBR

6.9 Clinical and resource implications for recommendations 31–50: organising healthcare services to meet the needs of people with BPD

6.9.1 Clinical implications of the recommendations

The recommendations to consider selective, targeted use of inpatient admissions for BPD treatment (recommendations 33–34) may reduce the distress experienced by people with BPD.

People with BPD are at high risk of suicide (see Section 1.5.1). Many people with BPD live with constant thoughts of suicide and make multiple attempts on their life. Adoption of these recommendations, supported by the additional guidance in Section 8.5, would improve care, and reduce distress and suffering.

Adopting a stepped-care approach (recommendations 38–40) will improve capacity to treat the prevalence of BPD in the community.

6.9.2 Resource implications of the recommendations

These recommendations may require education for primary care health professionals to improve understanding of the seriousness of crises for people with BPD and their need for acute care.

The recommendations to provide care for people with BPD within their community (recommendation 31) and through a range of health services (recommendation 32) may require investment in community and outpatient health centres, to ensure that healthcare professionals receive adequate training and support to implement these recommendations. Service planners will need to undertake mapping of services and fill gaps.

The recommendations for selective, targeted use of inpatient admissions for BPD treatment (recommendations 33–34) may challenge the limited capacity of some mental health inpatient facilities. Service planners and policy makers will need to consider the impact of increased admissions.

Adopting a stepped-care approach (recommendations 38–40) could reduce the burden on inpatient services by managing people in a community setting, where appropriate. However, its effective implementation depends on access to specialised services, which are currently limited. Service planners will need to consider how to best support health professionals to ensure effective referral pathways, particularly in rural and remote regions.

The recommendation for referral to specialised BPD services (recommendation 37) may reduce the burden on services by reducing the number of hospitalisations. However, specialised services for people with BPD are limited. Implementation of this recommendation will require substantial investment in specialised BPD services throughout Australia.

The recommendation for basic BPD training for health professionals across all health services (recommendation 38) will necessitate investment in time and training costs.

Implementing the recommendations for supporting health professionals to care for people with BPD (recommendations 46–50) will require service planners to consider the cost of impact of the training, reduced caseloads, and supervision of health care professionals managing patients with BPD.

7. Supporting families, partners and carers

7.1 Influence of families, partners and carers on BPD

Literature was systematically searched and assessed to identify whether the ways that family, a partner and/or carers interact with a person with borderline personality disorder (BPD) can influence clinical outcomes, social outcomes or wellbeing (clinical question 25).

The search strategy and evidence synthesis process are detailed in Appendices D to H

7.1.1 Summary of evidence: influence of families, partners and carers

No studies were identified.

The UK national BPD clinical practice guideline¹ (in the absence of a systematic evidence review) identified limited evidence from prospective longitudinal studies of people with BPD that included baseline measurement of the quality of family relationships²⁴² and with family levels of expressed emotion.²⁴³

7.1.2 Discussion: influence of families, partners and carers

The relationship between the family environment and the prognosis for BPD is complex.¹ There is some tentative evidence that families of people with BPD could interact in ways that are not helpful for the person.¹ In one prospective study, the quality of participants' relationships with family members (parents, spouse, siblings and children) at baseline was associated with BPD outcome after 2 years.²⁴²

Another prospective study found that people with BPD whose families scored higher on an interview-based measure of emotional over-involvement (reflecting exaggerated emotional response to the illness, devoted or self-sacrificing behaviour, dramatisation or overprotective behaviour) experienced fewer admissions for BPD than those whose families scored lower on this measure.²⁴³ This limited evidence suggests a lack of association between family hostility and criticism and re-admission rates for family members with BPD.¹ The findings of one study among families of people with BPD suggested that higher knowledge of BPD was associated with higher burden, depression, distress and hostility towards the person with BPD.²⁴⁴ This unexpected finding suggested that people may have been obtaining misleading information through unhelpful information sources.

It is difficult to interpret findings from studies assessing the influence of family relationships on BPD because it is not possible to determine the degree to which temperamental vulnerability explains BPD outcomes, compared with family environment.¹ Based on current evidence and expert opinion, it is incorrect for health professionals to assume that all family environments are 'toxic' and have 'caused' the person's BPD.¹

Adolescents with BPD experience high rates of family breakdown. Australian data suggest that by a mean age of 16 years, approximately 37% of people with BPD are not living with either biological parent,¹⁸⁴ and this increases to 53% by mean age 18 years.¹⁸⁹

The Committee determined that there was insufficient evidence to make specific evidence-based recommendations on the potential influences of family, partners and/or carers on health outcomes for people with BPD. In making consensus-based recommendations for health professionals working with families and carers, the Committee agreed on the following considerations.

Some actions or behaviours by family, partners or carers might worsen BPD symptoms or reduce the effectiveness of treatment for BPD:

- Denial that the person has BPD might prevent the person getting help.
- Misunderstanding of the illness might lead to unrealistic expectations of treatment. For example, a false belief that “if they can only find the right treatment they will be completely cured” could result in unhelpfully encouraging the person to keep seeing new health professionals. This could disrupt ongoing treatment.
- Although some types of habitual self-harm are distressing for the person’s family or partner, demands to stop this behaviour can be counter-productive and increase the person’s distress. The person may need treatment and time before they can give up this behaviour. An empathic response may be more helpful.
- If families, partners or carers become aggressive when communicating with the person with BPD, this might cause further distress or worsen symptoms.
- While trying to avoid a hostile or aggressive emotional response from the person with BPD, their family, partner or carers may give in to the person’s wishes and agree to an action or decision that they do not believe will really help the person, rather than risk confrontation. A person with BPD may learn over time that they can achieve short-term goals by manipulating family/partner/carers’ emotions. This pattern could prevent them learning new, more helpful ways of behaving towards people.
- Family members, partners or carers can be overly protective and repeatedly try to ‘rescue’ the person with BPD. These behaviours might prevent the person learning to become independent.
- If families, partners or carers feel overwhelmed or intimidated by health professionals, they may not ask questions or ask for clarification of things they don’t understand. This could result in treatment decisions being made without a full understanding of options and their potential advantages and disadvantages.
- Accessing highly stigmatising, blaming information about BPD may be counterproductive.

Family members, partners and/or carers can support people with BPD by:

- **gaining knowledge and an understanding of BPD** – learning about BPD and how to cope with their own distress caused by the illness; understanding that BPD is an illness like any other illness helps avoid guilt, blame, stigma
- **developing helpful attitudes towards the person**
 - showing empathy – being willing to try to understand the experience of the person with the illness, including internal emotional pain
 - showing a non-judgemental attitude – accepting that when people with BPD experience uncontrollable emotions they often direct their anger or difficult behaviour towards those closest (family, partner, carers); understanding that during an episode of difficult emotions the person with BPD may say or do things that they would not say or do at other times, and that do not express how the person normally feels about the family member, partner or carer

- **encouraging independence**

- allowing the person to retain independence – avoiding the temptation to try to control the person's life for them; giving support and help when the person needs it yet allowing them to make their own decisions
- negotiating with the person about their decisions for managing their illness. However, occasionally families or carers may need to take action that overrides the person's wishes (e.g. for their safety)
- trying to balance their own needs and wishes with the amount of support the person with BPD needs to manage their illness well

- **developing helpful styles of communication**

- allowing the person with BPD to discuss their problems and worries honestly
- listening to the person with BPD when they express their desires, and respecting their desires even if they do not agree with them

- **cooperating with healthcare services**

- building good working relationships with healthcare services and providers, and including the person with BPD when dealing with healthcare services
- being honest and frank when dealing with healthcare services and providers
- making an agreement with the person about what information can be shared between health services and the family, partner and/or carer. When a person with BPD negotiates a management plan with a health provider, it may be essential to communicate this information to the person's family, partner or carer. The person's illness may make them unwilling to include the family, partner or carer sometimes. During periods of illness, a person with BPD may request their family, partner and/or carers not be involved with their care. A pre-established consent agreement can help in this situation. When families, partners and/or carers discuss the person's situation with healthcare services, the need for disclosure of information that will help health professionals plan appropriate care must be balanced by respect for the person's privacy. It is best for families, partners and/or carers to negotiate confidentiality while the person is well, and then negotiate with health services to establish an agreed set of 'rules' for sharing information, so that when the person is unwell and cannot make decisions capably, health services and families, partners and/or carers can share appropriate information as necessary to plan their care. The agreement may include information about diagnosis, medication and management plans.

7.1.3 Recommendations: influence of families, partners and carers

Recommendations directed towards family members and carers are outside the scope of this guideline. Recommendations for health professionals, based on the above considerations, are shown at Section 7.2.3.

7.2 Interventions directed at families, partners and carers to support the care of a person with BPD

Literature was systematically searched and assessed to identify whether interventions should be offered to families, partners and carers, specifically with the aim of improving the care of a person with BPD (clinical question 26).

The search strategy and evidence synthesis process are detailed in Appendices D to H

This section focusses on the needs of the person with BPD. The needs of families, partners and carers are discussed separately in Sections 7.3–7.4.

7.2.1 Summary of evidence: supporting family, partners and carers

No studies were identified.

7.2.2 Discussion: supporting family, partners and carers

The Committee determined that there was insufficient evidence to formulate evidence-based recommendations for interventions directed towards families, partners and carers to support BPD care. In formulating consensus-based recommendations, the Committee agreed on the following considerations.

Families, partners and carers can play an important role in supporting the person's recovery. Health professionals should acknowledge and respect their contribution.

Some people with BPD prefer not to involve their family, partner or carers until they have developed a trusting relationship with clinicians. The person's decision should be respected, and the choice offered again later when they are functioning well. The involvement of a person's family, partner or carers should be continually reviewed.

Health professionals can develop good working relationships with families, partners and carers of people with BPD by acknowledging their important role in the person's recovery, recognising their personal knowledge of the person, and respecting their views and concerns (Table 7.1). Such a relationship enables effective collaboration in the person's care. Families, partners and carers can reasonably expect the service provider to communicate with them effectively and to share information that is important to ensure the person receives quality care.

Health professionals who are in contact with their clients' families, partners and carers can help them in their supporting role by:

- providing psychoeducation or referring families, partners and carers to psychoeducation programs e.g. Well Ways program and information (www.mifa.org.au/well-ways). These programs can help families, partners and carers to understand the illness, learn how to cope and interact with the person in a way that helps in their recovery and allows them to maintain their lives and lifestyles where possible, develop ways of communicating so that they can support the person and communicate effectively with health professionals caring for the person, and overcome harmful effects of guilt and stigma.
- providing information or directing families, partners and carers to sources of reliable and helpful information about the illness, e.g. Well Ways program and information (<http://www.mifa.org.au/well-ways>), and *Borderline personality disorder: A brochure for family and friends* produced by Spectrum Personality Disorder Service for Victoria (available at <http://www.spectrumbpd.com.au/media/Resources/Family%20Brochure.pdf>)
- involving families, partners and carers in developing a crisis plan (with the person's consent), providing education on how to manage suicidal crisis, and directing them to reliable information about dealing with suicide attempts or self-harm behaviour, e.g. Mental Health First Aid materials and support (<http://www.mhfa.com.au/cms/>), and the Royal Australian and New Zealand College of Psychiatrists' booklet *Self-harm. Australian treatment guide for consumers and carers* (<http://www.ranzcp.org>).²⁴⁵ Health professionals should explain the difference between suicidal behaviour and other kinds of self-harm.

Health professionals should be aware that families, partners and carers may feel blamed for the person's BPD, and should show sensitivity and a non-judgmental attitude. It is helpful to remind family, partners and carers that not all people with BPD have a history of abuse or neglect, and that the condition is partly due to genetic and biological factors. When providing families or carers with information about the role of trauma in the development of BPD, health professionals should be sensitive and non-judgmental. If the treating clinician wishes to discuss the role of trauma in a specific case, these discussions should only take place with the consent of the person with BPD. Health professionals should manage these discussions in a manner that minimises guilt, stigma and blame.

When working with adolescents and young people with BPD, health professionals should be aware that families may share similar social and interpersonal difficulties. Family problems should be acknowledged, and family members should be supported and educated to be involved in the young person's care.

Services should also continue to support and collaborate with families or carers, even if consent has not been given. Families, partners and carers should be given up-to-date information about BPD regularly. Families, partners and carers should be given support and advice for dealing with challenging situations and at times of crisis, if they ask for this.

Consent to share information with the person's family, partner or carers should be documented. It is not unusual for people with BPD to refuse to identify their carers or involve them, or to change their mind later.

Table 7.1 Principles for collaborating with families and carers

1. Recognise, value and support families, partners and carers in their care-giving role.
2. Communicate with families, partners and carers and share information to ensure quality care, if appropriate.
3. Involve the person's family, partner or carers when developing and reviewing the BPD management plan, if possible.
4. Develop a separate crisis plan for families, partners and carers to use.
5. Encourage carers to ask questions and discuss their concerns.
6. Help families, partners and carers to navigate health services.
7. Consider families', partner's and carers' language and culture.
8. Provide families, partners and carers with information about the diagnosis and treatment of BPD and the management strategies available to the person, including management of crises.
9. Respect the person's right not to involve their family, partner or carers, if they so decide.
10. Refer to Australian National Standards for Mental Health Services¹⁶¹ to determine which information may be given to family members and carers.

Adapted from Project Air Strategy *Treatment guidelines for personality disorder*¹⁸²
(available at www.projectairstrategy.org)

7.2.3 Recommendations: supporting family, partners and carers

	Recommendation	Grade
R51.	Health professionals should refer families, partners and carers of people with BPD to support services and/or psychoeducation programs on BPD, where available.	CBR
R52.	Health professionals should provide families, partners and carers of people with BPD with information about BPD or direct them to sources of reliable information.	CBR
R53.	Health professionals should include families, partners and carers of people with BPD when developing crisis plans, if possible and with the person's consent.	CBR
R54.	Health professionals should provide families, partners and carers of people with BPD with information about dealing with suicide attempts or self-harm behaviour.	CBR
R55.	Health professionals should advise families, partners and carers of people with BPD about helpful ways of interacting with the person who has BPD, including: • showing empathy and a non-judgemental attitude • encouraging the person to be independent by allowing and supporting them to make their own decisions, but intervening for their safety when necessary • listening to the person with BPD when they express their problems and worries.	CBR
R56.	When discussing childhood trauma, including sexual abuse, with the family of a person with BPD, health professionals should manage these discussions in a manner that minimises guilt, stigma and blame. Such discussions should occur with the consent of the person with BPD, (taking into account child protection legislation if the person is a minor).	CBR

7.3 Needs of families, partners and carers

Literature was systematically searched and assessed to identify specific care needs of families, partners and carers of people with BPD (clinical question 23).

The search strategy and evidence synthesis process are detailed in Appendices D to H

7.3.1 Summary of evidence: family, partner and carer needs

The UK national BPD clinical practice guideline¹ (in the absence of a systematic evidence review) identified three studies relevant to the specific care needs of families, partners and carers of people with BPD, which included questionnaire-based studies of personality traits²⁴⁶ and symptoms of psychological distress.^{247, 248} However, the Committee determined that these studies did not provide sufficiently specific evidence on the needs of families and carers.

The updated systematic review identified no further studies that provided evidence on care needs of families, partners and carers.

7.3.2 Discussion: family and carer needs

Families, partners and carers of people with BPD may have needs that are at least equivalent to families, partners and carers of people with other severe and enduring mental health problems:¹

- families and friends of people with BPD experience higher rates of psychological symptoms than the general population²⁴⁸
- families of people with BPD experience significant burden of care (as measured by the Burden Assessment Scale and Perceived Burden Scale), significant depression (as measured by the Revised Centre for Epidemiological Studies Depression Scale), significant grief (as measured by a grief scale), and low levels of mastery as measured on the Mastery Scale.^{246, 247}

A report by the Mental Health Council of Australia²⁴⁹ identified major priorities to address needs and problems of families and carers of people with a mental illness (Table 7.2). The report noted that, although carers were asked to identify their own needs, their most pressing concerns were for better care and services for people with mental illness, rather than services for themselves.²⁵⁰

The Committee determined that there was insufficient evidence to make specific evidence-based recommendations on providing for the needs of families, partners and carers of people with BPD. In formulating consensus-based recommendations, the Committee agreed on the considerations in sections 7.3.2.1–7.3.2.4.

Table 7.2 Priorities for carers of people with mental illness

1. Listen to and respect carers
2. Integrated recovery-based care for the consumer
3. More and better trained staff at all levels
4. Knowledge and information for carers
5. Carer and consumer education for all professional groups and agencies
6. Support systems, services and processes established for carers
7. Acute care to be therapeutic and accessible
8. Stigma, discrimination and isolation for carers and consumers
9. Accommodation options for consumers at all levels of care
10. Financial costs to carers
11. Physical and mental health of carers
12. Flexible respite options for carers
13. Privacy and confidentiality issues
14. Early intervention at each episode of care
15. Employment options for carers

Source: Mental Health Council of Australia. *Adversity to advocacy: the lives and hopes of mental health carers*, 2009.²⁴⁹

7.3.2.1 Adult family members, partners and carers

Family members, partners and carers may experience emotional distress, including:

- a sense of blame and guilt (either thinking that they have contributed to the person's illness, or thinking that they should have known the person was unwell before the diagnosis)
- stigmatisation and lack of understanding from their community or within their own family/social group
- anxiety about being required to make difficult decisions about the person's care. Families, partners and carers may be distressed at taking on extra responsibilities, whether willingly or reluctantly. Family members may feel that the community expects them to take a carer role, even if they do not feel equipped to do this. Uncertainty due to their ever-changing role and circumstances and the unpredictability of the illness may lead to anxiety.
- significant grief and loss, which may involve difficulties adjusting to changes in their life goals or role due to the person's illness. Family members and carers may place their own life or career aspirations on hold to care for the family member or friend.
- social isolation due to caring responsibilities
- conflict between their relationship with the person and their relationship with others when confronted with the need to make difficult decisions about day-to-day family life. Occasionally the behaviour of the person with BPD may be a risk to their family (e.g. children). Families, partners and carers may have to ask the person with BPD to leave. In some situations, families, partners and carers may have no choice due to involvement of authorities.

Families, partners and carers may experience financial problems due to their caring responsibilities (e.g. a reduced capacity for paid work, medical expenses and treatment-related costs such as transport). Families, partners and carers may sometimes face legal problems due to incidents in the community or at home that require police intervention.

7.3.2.2 Children and young people who are carers

Young people caring for a person with BPD face special problems, especially the children of a single parent who has BPD (however, single parents with BPD can be capable parents, particularly when given appropriate support). When a parent has serious mental health problems, their child may provide high levels of emotional care and nursing-type responsibilities such as administering medicines, as well as participating in household tasks.²⁵¹

The young person/carer may be required to take on the parent role during times that the parent is too unwell. This can lead to problems in the parent-child relationship when the parent with BPD is again well enough to resume the parenting role.

The responsibilities of caring for a parent with BPD may result in absence from school or inability to complete homework, or loss of contact with friends. Young carers are at risk of leaving school early.²⁵² Long-term caring responsibilities for a child can result in poor educational attainment, low self esteem and difficult transitions into adulthood.²⁵¹ A young person who is experiencing difficulty expressing emotions about a parent with a mental illness may develop attention-seeking behaviours or other difficult behaviours.

7.3.2.3 Children of parents with mental illness

Children who have a parent with a mental illness affecting mood have a 40% chance of experiencing an episode of depression by the age of 20, which increases to 60% by the age of 25.²⁵³

Children can experience strong grief and loss when separated from a parent due to mental illness, even for a short time. The child's life can be severely disrupted if the parent goes to hospital especially if the child needs to move to be cared for.²⁵² Hospitalisation is considered one of the most stressful aspects of coping with a parent's mental illness.²⁵⁴ Some studies suggest that approximately 20–30% of the children whose parents are hospitalised due to mental illness show signs of emotional or behavioural problems.²⁵⁴ Many children do not show obvious signs of distress while their parent is hospitalised for acute psychiatric crisis due to mental illness, but symptoms may develop when the child is older.²⁵⁴

Pre-school children may have fewer opportunities to interact with and learn from other children when the parent's mental illness limits the child's access to pre-school or recreational outings.²⁵⁵ Pre-school children may not have the language skills to describe their observations and perceptions, but they will be aware of parental mental illness.²⁵⁵ Pre-school aged children need to be included in conversations about what is happening, using language appropriate to their age that is concrete and provides reassurance.²⁵⁵ It is important to let the children know that it is not their fault that their parent is unwell, and to give them information that dispels or reduces worry and feelings of helplessness.²⁵⁵ Pre-schoolers should be reassured that if their parent is unable to care for them there is someone who will until their parent is well enough.²⁵⁵

Health professionals caring for a parent with mental illness should observe the person's children for signs of distress. Behaviours such as withdrawal or acting out, extreme responses to situations, inappropriate familiarity with strangers or an inability to seek comfort from their parent may indicate that the child needs help.²⁵⁵

7.3.2.4 Infants of mothers with BPD

Mothers with BPD and their infants might show disturbed patterns of interaction, compared with mothers and infants in the general community,²⁵⁶ and mothers with BPD experience specific parenting issues.²⁵⁷

Physical absence of a parent due to mental illness or emotional unavailability of the parent may lead to disruption of the process of attachment between infant and parent.²⁵² Infants of people with mental illness can develop insecure or disorganised attachments if interaction between the parent and child is disrupted due to the parent's symptoms or effects of medicines.²⁵⁵ There is emerging evidence that severe mental illness in a parent increases an infant's risk of multiple mental and developmental problems.²⁵⁸

7.3.3 Recommendations: family, partner and carer needs

	Recommendation	Grade
R57.	Health professionals caring for parents with BPD should consider the needs of children and arrange assessment of their mental health and welfare needs if necessary.	PP
R58.	Health professionals assessing a person with BPD (particularly during a crisis) should determine whether the person has dependent children and ensure that they are properly cared for (e.g. refer to a social worker).	PP

7.4 Interventions to meet families', partners' and carers' needs

Literature was systematically searched and assessed the effectiveness and efficacy of specific interventions offered to families, partners and carers of people with BPD to meet family members' and carers' own needs (clinical question 24).

The search strategy and evidence synthesis process are detailed in Appendices D to H

7.4.1 Summary of evidence: caring for families, partners and carers

The UK national BPD clinical practice guideline¹ (in the absence of a systematic evidence review) identified four studies, including two studies assessing the effects of a 12-week program of education, skills and support designed for relatives of people with BPD and based on dialectical behaviour therapy.^{247, 259}

The Committee did not consider the two other studies that proved to be irrelevant: a study of family psychoeducation that was not specific to families of people with BPD²⁶⁰ and a study that correlated family members' knowledge about BPD with their levels of depression, burden, distress, and expressed emotion.²⁴⁴

The updated systematic review identified no further studies that provided evidence on appropriate interventions to meet the care needs of families, partners and carers.

7.4.2 Discussion: caring for families, partners and carers

Emerging evidence suggests that structured family programs may be helpful in reducing grief and burden of care, and in improving family members' sense of control over their situation.^{1, 247, 259}

The Committee determined that there was insufficient evidence to formulate evidence-based recommendations. In formulating consensus-based recommendations for appropriate interventions to offer families and carers of people with BPD, the Committee agreed on the following considerations.

Health professionals can support families, partners and carers by referring or directing them to:

- general family counselling and psychoeducation with a focus on BPD
- structured family programs specific to BPD
- peer support programs such as carer-led programs that educate families/carers on BPD.

In addition, the considerations listed in Section 7.4.2.1 apply to the children of people with BPD.

7.4.2.1 Children of parents with BPD

For people with BPD who have young children, the care and wellbeing of children should be considered (Table 7.3).²⁵²

Health professionals should advise authorities that a parent's BPD alone is not a sufficient reason for removing a child from the parent's care. Parents with BPD can be capable parents, particularly when given appropriate support. If health professionals identify any risks to a person's children as a result of their mental illness, they should speak to the person openly about professional responsibilities for children's safety and explain any action they are required to take.²⁵¹

Some parents may need support to look after their children. In some circumstances, priority must be given to the protection of the child. Health professionals must maintain communication and collaboration between all services involved, especially when the parent has a co-occurring condition such as a substance use disorder, or when mental health services are provided mainly by a private practitioner.²⁵²

While the person is well, plans can be made by the person in collaboration with their family and health professionals for the care of children, so that the best decisions can be made when the parent becomes unwell as a result of their mental illness (known as advance care plans, care plans, crisis plans, advanced directives or Ulysses agreements).²⁵³ These plans can range from simple verbal agreements to carefully crafted documents that can be shared with others and usually include the purpose of the plan, symptoms of the illness, unique family strengths, issues of communication and confidentiality, a wellness plan of action, children's needs, and conditions for cancellation and evaluation.²⁵³ The plan should involve extended family and friends. Health professionals can only help a family develop such an agreement if the family already trusts them and feels safe working with them.²⁵³ Advance care plans are a practical way to show children that adults in their world are keeping them in mind.²⁵⁵

A mother's mental illness may affect an infant's relationship with his/her mother and the infant's development, so clinicians treating a woman with mental illness should also consider the infant's needs.²⁶¹ An attachment-focussed psychotherapy ('Watch Wait and Wonder'), designed to improve the interaction between mothers with BPD and their infants, is currently being assessed.²⁶²

If a mother requires hospitalisation, a joint admission with her infant will allow for the needs of both mother and infant to be addressed and the fostering of the mother-infant relationship.²⁶¹

Family-focussed interventions are effective in reducing internalising symptoms in children who have a parent with a mental illness.²⁵⁸ Interventions for pre-school aged children who have a parent with mental illness include:²⁵⁵

- individual therapy with the child, accompanied by parallel sessions with the parent for those children who find it difficult to express themselves in front of their parent, as they are fearful of hurting their feelings, or where children are over-reliant on their parents and the parent is overprotective
- child-parent group interventions such as the 'Circle of Security'. Circle of Security is an intervention based on attachment theory, which aims to establish the parent as a secure base for the child
- parenting programs that focus on enhancing parents' capacity to encourage their children to talk about their feelings so they learn that their parents are there to help them understand and manage their emotions
- home visiting programs to support parents in fulfilling their parenting role and to meet the developmental needs of their child.

Table 7.3 Checklist for health professionals caring for children of parents with a mental illness

Promoting children's wellbeing and reducing risk to children

Mental health professionals can help parents with mental illness, while they are well, to plan with families for care of children and management of family affairs for when they experience relapse and are temporarily unable to care for children.

Adult mental health professionals, in collaboration with child and family mental health professionals, can promote wellbeing and reduce risk for children of people with mental illness by:

- identifying at initial contact where the person with a mental illness is a parent (or pregnant)
- ensuring that the child's needs are assessed when a parent's mental illness is first identified, and reviewed periodically afterwards
- notifying child protection services if they believe that a child is at significant risk of neglect or maltreatment
- helping parents with mental illness to identify their strengths as parents and any support they need to help them care for their child
- working with teachers to ensure appropriate assessment of children so that, if a child of a person with mental illness is showing signs of physical or psychosocial problems, these are identified early
- encouraging positive attachment between parents and children
- identifying factors that may increase risk to the child's safety and welfare such as co-occurring substance abuse, intellectual disability, domestic violence or homelessness.

Mental health professionals can also prevent or minimise harm to children and their parent with mental illness by:

- helping people with mental illness who intend to have children or are pregnant to access early antenatal care
- helping them get advice about family planning
- identifying and treating behaviours that may harm the children's health or wellbeing (e.g. counselling, pharmacological therapy where appropriate)
- taking into account their parenting role and responsibilities when planning mental health treatment.

If there are concerns about a child's safety due to a parent's mental illness, mental health professionals can support families by:

- assessing short and long-term effects of the parent's mental illness and its treatment on the child
- assessing needs of the family as well as individual members, and responding to these needs
- advocating support for the family to meet the identified needs
- providing information about local support services, and help to access them if necessary
- (if a child is assessed to be at risk of neglect or maltreatment) collaborating with child and family health professionals and the nominated child protection case manager to develop a plan for ensuring safety of the child and to help monitor the plan.

Table 7.3 (cont.)

Addressing grief and loss issues

Mental health professionals can help family members where a parent has a mental illness to minimise or reduce feelings of grief and loss in the following ways:

- working together to implement prevention strategies and early intervention strategies to improve the quality of relationship between parent and child, and avoid separation
- if a child is separated from one parent, supporting the child's right to maintain relationships with both parents regularly (unless this has been assessed as not in the child's best interests)
- if a parent and child are temporarily separated due to a parent's mental illness, planning and helping reunion
- if a parent is unable to be the primary carer for the child due to mental illness, providing support for both parent and child
- if a child is not in the care of the parent with a mental illness, offering parent strategies to promote and strengthen the child-parent relationship
- identifying and managing feelings of grief and loss about child care experienced by a parent or other family members due to the parent's mental illness.

Access to information, education and decision making

Mental health professionals can help children of a person with a mental illness to get information, education and help with the process of decision-making in the following ways:

- talking to the parent with a mental illness about their concerns about confidentiality, and telling them about how children benefit from information about their parent's mental illness that is appropriate for the child's age
- helping the child get information about their parent's mental illness while maintaining the parent's right to confidentiality
- encouraging parents with a mental illness to talk to their children about their mental health and illness, and providing resources (e.g. books, videos) that can help them do this
- supporting parents with a mental illness to discuss early warning signs of their condition with their older children or with other adults, to make sure they know what to do (especially what to do to make sure younger children are properly cared for)
- supporting children of a person with mental illness to participate in making decisions about the person's care, provided the parent gives permission for child to be involved
- when a parent has experienced a mental health crisis, providing (or referring to) debriefing services for the person's children appropriate for their age
- providing the opportunity for children to talk about their concerns about developing the same illness as their parent
- when young people have a major responsibility for caring for a parent with a mental illness, ensuring the young people have access to information about their parent's care and are involved in discharge planning if the parent is hospitalised
- helping parents with a mental illness gain insight into their illness and its possible effects on their family by providing information about diagnosis, prognosis, management and services.

Child and family health professionals can help the children of a person with a mental illness to get information and education by encouraging the parent to speak to their children about their illness, and providing resources to help them.

Source: Australian Infant Child Adolescent and Family Mental Health Association. *Principles and actions for services and people working with children of parents with a mental illness*²⁵²

7.4.3 Recommendations: caring for families, partners and carers

	Recommendation	Grade
R59.	Health professionals can support families, partners and carers by referring or directing them to: • general family counselling and psychoeducation with a focus on BPD • structured family programs specific to BPD • peer support programs such as carer-led programs that educate families/carers on BPD • respite services.	CBR
R60.	If a mother with BPD requires hospital admission, separation from her infant should be avoided if possible.	PP
R61.	Health professionals involved in the assessment of parenting capacity should advise authorities that a parent's BPD alone is not sufficient reason for removing a child from the parent's care.	PP
R62.	People with BPD who have infants or young children should be provided with interventions designed to support parenting skills and attachment relationships.	PP
R63.	Where children are carers of an adult with BPD, specific support should be provided, including: • education about the parent's mental illness • strategies for management of the adult's emotional and psychological states • strategies for helping them with peer relationships and social functioning • psychological and emotional support • referral to services for young people who are carers • respite services.	PP

7.5 Clinical and resource implications for recommendations 51–63: supporting families, partners and carers

7.5.1 Clinical implications of the recommendations

Implementation of the recommendations for involvement of families, partners and carers of people with BPD (recommendations 51–56) would significantly improve the relationships between health professionals and significant others of people with BPD.

Strategies designed to raise health care professionals' awareness of this clinical approach may be required to implement these recommendations.

Implementation of the recommendation to allow women to be admitted to an inpatient facility with their infants (recommendation 61) may increase demand for specialised mother–baby inpatient psychiatric facilities.

7.5.2 Resource implications of the recommendations

In order to consider the social welfare needs of children of people with BPD (recommendations 61 and 62), health professionals require guidance and mentoring from appropriately trained health workers.

Implementation of recommendations for supporting families, partners and carers (recommendation 59) may result in increased demand for family support services, including peer support services.

Implementation of recommendations to support children who are carers of a parent with BPD (recommendation 63) may result in an increased demand for specific support services.

8. General principles for treatment and care of people with BPD

This chapter provides general guidance for health professionals caring for people with BPD and is based on expert opinion. The principles of care described in this section support the evidence-based recommendations in chapters 4–7.

The information in this chapter applies to all health professionals who work with people who have BPD, even if they do not provide specific treatment for the condition.^{af} All health professionals are able to gain and use the skills required to apply these principles.

Some of these principles do not apply only to people with BPD, but represent the principles of excellent care in any health profession. However, attention to these principles is especially important when working with people who have BPD, because these people may be sensitive and vulnerable.

The process of therapy is often considered to represent a ‘journey’ aimed at understanding the individual’s life in detail and allowing the person to come to know and understand the ‘self’ in greater depth. In general, this guideline recommends structured, time-limited treatment approaches. Yet it is recognised that, for a particular individual, approaches such as psychodynamic therapy might require longer-term treatment. It is not possible to predict the time it might take to develop an adequate understanding of the person’s inner world and internal pain.

The advice in this chapter is based on consensus and drawn from a variety of sources including the UK national BPD clinical practice guideline¹ and publications by the Project Air Strategy¹⁸² and Spectrum.¹⁶²

8.1 Gaining trust and managing emotions

Many people with BPD will have experienced rejection, abuse and trauma, and encountered stigma that is associated with self-harm and other BPD symptoms.¹ They may also have had problems working with healthcare professionals due to difficulty controlling their emotions and their tendency to feel threatened by relationships. Health professionals should be aware that adult survivors of childhood sexual abuse who have BPD have special needs, and often have trouble accessing services that are sensitive to these needs. Table 8.1 summarises general principles for working with a person with BPD.

People with BPD may find it difficult to trust and engage with others.¹ Gaining the person’s trust is an important first step in helping them. Health professionals and other staff should encourage trust by showing a non-judgemental attitude and by being consistent and reliable (e.g. by keeping appointment times, making arrangements for contact outside the planned appointment schedule that are feasible to sustain long-term, planning for staff continuity over time, and explaining the team structure and team members’ roles to the person).

^{af} In this guideline the ‘main clinician’ means the health professional (e.g. GP, psychiatrist or psychologist, therapist or case manager) who is the person’s designated main point of contact and takes responsibility for coordinating the care provided by other services, if applicable.

Health professionals should be aware that they will have emotional reactions to people with BPD and their circumstances, and should try to ensure that these feelings do not lead to poor clinical decisions. For example:

- A health professional who takes personally a comment made by an upset person may have difficulty showing empathy and offering ongoing medical care.
- A doctor may be tempted to prescribe medicines out of sympathy or in response to the person's request, even when the prescription is unlikely to be effective or carries a risk of dependence in future (e.g. opioid analgesics or benzodiazepines).
- A health professional's actions may be inappropriately influenced by the person's attitude toward them.
- Staff of a health service may respond to a person's emotional neediness by being overprotective, causing them to offer types of care that are not in the person's best interest but merely ease the staff's own anxiety or desire to help.

Each of the structured psychological treatments mentioned in this guideline have methods for addressing relational difficulties between patients and clinicians.²⁶³

When receiving treatment from more than one healthcare provider or dealing with more than one staff member, a person with BPD may perceive one person as helpful and another as unhelpful, and therefore respond very differently to each. This situation can lead to misunderstandings or tension between team members and may compromise collaborative care.

Health professionals need to be aware that a person with BPD may act very differently at different times – not in a deliberate attempt to deceive the health professional, but in responses to perceived threats and fears.²⁶³ When faced with provocation, clinicians and other staff should respond in accordance with the principles outlined in Table 8.1. If the person makes a threat, it may be better to respond empathically to their distress than to react defensively.

Problems caused by health professionals' reactions to the person's attitude can be prevented or managed through effective leadership within teams and effective communication between health professionals.¹ Teams working with people with BPD should review regularly the team members' ability to cope and their tolerance and sensitivity towards their clients.¹ Health professionals working alone should participate in peer consultation and supervision.

Table 8.1 Principles for working with people with BPD

- Be respectful.
- Show empathy and a caring attitude.
- Be consistent and reliable.
- Listen and pay attention to the person when they describe their current experience and take it seriously.
- Validate the person's current emotional state and allow the person to express strong emotions.
- Maintain a non-judgemental attitude.
- Stay calm.
- Communicate clearly.
- Express hope about the person's capacity for change and give encouragement, but don't give false assurances about the ease and speed of recovery.

Adapted from Project Air Strategy *Treatment guidelines for personality disorder*⁴⁸² (www.projectairstrategy.org) and the UK national BPD clinical practice guideline¹

8.2 Setting boundaries

People with BPD may miss appointments, demand to be seen immediately without an appointment, or stop attending a health service without discussing cessation of treatment with the health professional. To avoid misunderstandings or unhelpful emotional reactions to conflicting expectations, health professionals and the person with BPD should negotiate and agree on how the person will access the health service and any limits of use. Agreed practices should be feasible and sustainable long-term.

Making the interaction between the consumer and the health service as consistent and predictable as possible can help the person feel safe. All staff in a health service should act consistently and thoughtfully.

During a crisis, a person with BPD may feel unable to cope and may expect other people to take responsibility for their needs.¹ Although health professionals may feel pressured to try to take care of the person, this may undermine a person's limited capacity to care for themselves. Health professionals should try to make sure the person stays involved in finding solutions to their problems, even during a crisis.¹

8.3 Managing transitions and endings

People with BPD are sensitive to feeling rejected or abandoned. Health professionals who have developed a significant relationship with a person with BPD should anticipate that withdrawal and ending of treatments or services, and transition from one service to another, may evoke strong emotions and reactions in the person.¹

Discontinuation of treatment by a healthcare professional or contact with a service should be carefully planned and managed, in consultation with the person (Table 8.2). Planning for transfer to another service or discharge from treatment should begin well in advance, because transfer takes longer to achieve safely in people with BPD than for other people who use mental health services. At the beginning of treatment it may be helpful for the clinician to explain that the treatment will eventually come to an end.

The treating clinician can help the person cope by emphasising any progress that the person has made towards recovery, clearly expressing confidence in the person's ability to manage their life now and after the end of treatment, encouraging the person to think about future goals and challenges and how they will approach these, and supporting the person to identify other sources of support.¹⁸² If appropriate, the treating clinician should also discuss plans for the end of treatment with the person's family, partner and carers.¹⁸²

If a person's contact with a health service must be discontinued for other reasons (e.g. when the person moves to another area or the health professional leaves the service), the situation must be handled carefully and sensitively.¹⁸²

Table 8.2 Planning transitions between services and treatments

- Ensure changes are structured and planned, in consultation with the person.
- Ensure that the person's BPD management plan includes collaboration with other healthcare providers during changes.
- Make sure the person knows who to contact during a crisis.
- When referring the person to another service for assessment or treatment, make sure they have support during this period.
- Clearly discuss planned changes in treatment with the person beforehand.
- Involve the person's family, partner and carers unless there is a clear, documented reason not to.

Adapted from the UK national BPD clinical practice guideline¹

8.4 Developing a BPD management plan

A tailored management plan, including crisis plan, should be developed for all people with BPD who are using health services.

The main clinician should be identified and should take responsibility for developing and reviewing the management plan, in collaboration with the person with BPD and others involved in their care, including emergency services. The person's family, partner or carers should be involved in developing the management plan, if this is in the person's interests and they have given consent for their family, partner or carers to be involved.

BPD management plans can help health professionals clarify their role and actions, and avoid inconsistency or chaos among treatment providers, validate the person's concerns, and help evoke empathy in health professionals and others involved in the person's care. Management plans should be flexible because they may need to be changed as circumstances change.

The BPD management plan should include short-term and long-term treatment goals, treatments, and a crisis plan (see Table 8.3 and Section 8.5.3). Treatment goals should be relevant to the person and determined mainly by them. Treatment goals should be realistic,¹ taking into account the fact that the person is likely to experience marked fluctuations in their symptoms, but can be expected to make substantial, sustained gains slowly over the long-term.

People with BPD vary in their capacity to use written management plans. In some cases, negotiation with the person will be verbal, and the written management plan will be primarily for the guidance of the treating team.

It is important to make sure a person has only one BPD management plan. All care providers should communicate with each other so that a coordinated management plan can be developed. Written management plans should be clear and concise, so they can be followed by a range of health services. Some people with BPD may already have a Mental Health Care Plan or general medical Care Plan prepared by their GP.^{ag} If different health professionals involved in the

^{ag} Medicare Chronic Disease Management initiatives that may apply include GP Management Plans and Team Care Arrangements. Refer to the Australian Government Department of Health and Ageing for information on related Medicare item numbers (available at <http://www.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare-chronicdiseasemanagement>). The Better Access to Psychiatrists, Psychologists and General Practitioners (Better Access) initiative may also apply (available at <http://www.health.gov.au/internet/main/publishing.nsf/content/mental-ba>)

person's care have been using different, or contradictory approaches, a meeting between health professionals would be helpful to ensure the person receives consistent care.

With the person's consent, the management plan (including crisis plan) should be shared with all health professionals involved in their care, and with carers. Sometimes, the person's request for confidentiality may limit the matters that can be discussed with other health professionals and carers. However, confidentiality concerns should not restrict communication between health professionals when issues of personal safety are at stake.

For people with BPD who repeatedly present during crises to emergency services or GPs, a clear and concise crisis plan should be available. The main clinician should provide the crisis plan to other services, with the person's permission.

The plan should be routinely reviewed at least every six months. It should also be reviewed:

- when the person first contacts a health service
- at the time of entry to a treatment program
- at discharge or transfer from a treatment program, service, or health service provider
- when there is a clinically significant change
- when there is a significant change in the person's family and social network.

Examples of templates for BPD management plans and crisis management plans are provided in Section 10.

Table 8.3 Components of a management plan for a person with BPD

The management plan should identify:

- the diagnosis and any co-existing mental health conditions
- short-term goals for treatment
- long-term goals for treatment
- situations that trigger distress or increase risk
- self-management strategies that reduce stress and risk
- strategies that have been used in the past with the aim of reducing distress, but were not helpful or made things worse
- who to contact in an emergency (see information on crisis planning in Section 8.5.3)
- health professionals, services and agencies involved in the person's treatment and their roles
- all other people helping with the person's treatment (e.g. family, partner, carers or friends), including their role in supporting the person
- the planned review date
- who has a copy of the plan (list people and services).

Adapted from Project Air Strategy *Treatment guidelines for personality disorder*¹⁸²
(available at www.projectairstrategy.org)

8.5 Assessing and managing risk of self-harm or suicide

8.5.1 Risk assessment for a person with BPD

General principles of psychiatric risk assessment apply when considering risk in people with BPD. However, clinicians treating people with BPD need to be aware of other factors that apply to people with BPD and should be taken into consideration.

Many people with BPD live with persistent thoughts of suicide. Chronically suicidal people (whether or not they have BPD) can think about or attempt suicide over the course of many years.²⁶⁴ Problems often begin in childhood or adolescence.^{264, 265} Eventually, suicidality might become part of a person's ongoing experience, unlike in people who experience temporary suicidal thoughts associated with depression. Some people with BPD may repetitively harm themselves in potentially lethal ways (sometimes relying on being rescued by another person), and are at high risk for accidental death over long periods of time.

A person with BPD may live with persistent thoughts of self-harm, but also experience acute self-harming impulses from time to time. Some people with BPD use self-harm as a way of regulating their emotions. This practice does not mean they are suicidal, especially if the pattern of self-harm is consistent over time. Self-harm and suicidal behaviours may co-occur in a person with BPD. Clinicians should try to distinguish these, if possible.²⁶⁶

Suicide attempts by people with BPD may be planned or impulsive. Some people with BPD use threats of suicide to communicate their distress to other people with whom they have a close interpersonal relationship, or to their therapist.²⁶⁶ Once a trusting therapeutic relationship is established, a person with persistent suicidal thoughts might disclose risk factors that require intervention, such as stockpiling of medicines intended for overdose.

Risk of self-harm or suicide fluctuates over time, so risk assessment should be ongoing. A thorough risk assessment for a person with BPD should be conducted:

- when the person first contacts a health service
- when the person begins a course of structured psychological therapy (see Section 5.1)
- during a crisis
- if the person develops another mental illness (e.g. a substance use disorder, depression or psychosis)
- if the person's psychosocial status changes
- at transitions between services or discharge from a treatment plan
- when the BPD management plan is being reviewed or altered.

A risk assessment should aim to identify changes in the following:^{182, 266}

- pattern of suicidal behaviours
- self-harm behaviours, distinguishing high-lethality self-harm from low-lethality self-harm, and the pattern of self-harm behaviours
- co-occurring mental illness or substance use
- the person's sources of psychosocial support
- the person's mental state, particularly identifying depression, hopelessness, and suicidal thoughts.

In addition to special indicators of suicide risk in people with BPD (Table 8.4), clinicians should consider indicators of suicide risk that apply to the general population, including people with BPD. In general, suicide risk is increased if a person:¹⁸²

- has a clear plan for suicide
- intends to use a method that is actually lethal
- has access to the intended means and it is feasible for them to carry out their plan
- does not hope to be rescued during the planned suicide attempt
- expresses feelings of hopelessness about their future
- has delusions that make them believe they must die
- has co-occurring depression or a substance abuse problem
- is not supported by a strong social network.

The clinician should also assess whether the person's behaviour may constitute a risk of harm to others, including dependent children.

All these factors should be considered when assessing the person's immediate and ongoing risk of suicide (Table 8.4 and Figure 8.1).

Table 8.4 Indicators of increased suicide risk in people with BPD

Factors associated with increased suicide risk, compared with previous level of risk, include:^{182, 266-276}

- changes in usual pattern or type of self-harm (Figure 8.1)
- significant change in mental state (e.g. sustained and severe depressed mood, worsening of a major depressive episode, severe and prolonged dissociation, emergence of psychotic states)
- worsening in substance use disorder
- presentation to health services in a highly regressed, uncommunicative state
- recent discharge following admission to a psychiatric facility (within the past few weeks)
- recent discharge from psychiatric treatment due to violation of a treatment contract
- recent adverse life events (e.g. breakdown or loss of an important relationship, legal problems, employment problems or financial problems).

Other factors associated with increased risk of suicide include:

- co-occurring mental illness
- antisocial or impulsive personality traits or a co-occurring antisocial personality disorder
- history of childhood sexual abuse, especially incest and prolonged abuse
- number and lethality of previous suicide attempts
- experiences of loss in childhood.

8.5.2 Risk management for a person with BPD

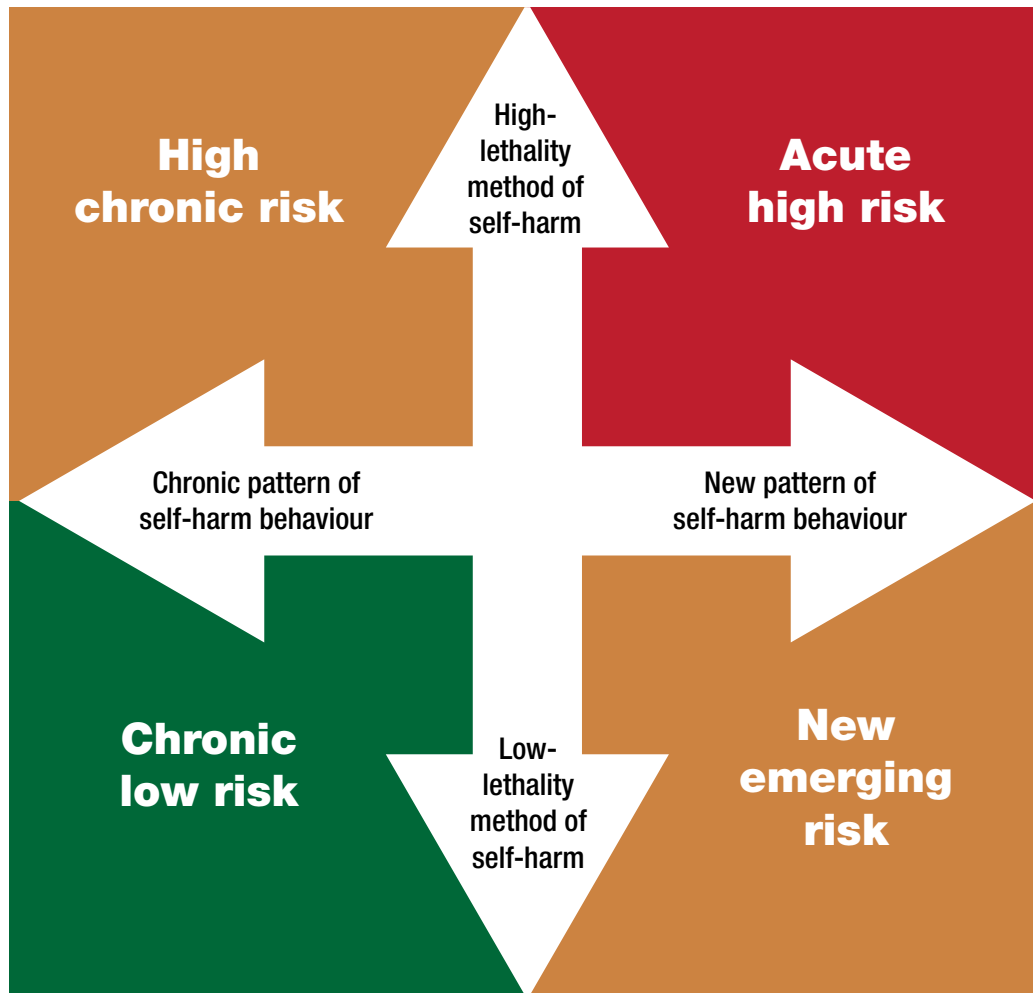
Threats of suicide by people with BPD should always be taken seriously.

Managing the risk associated with chronic suicidality is different from managing risk associated with acute suicidality.²⁶⁴ In chronically suicidal people, active attempts to prevent suicide, such as hospital admission and close observation, may be unhelpful or even escalate risk.^{277, 278} It may be necessary to tolerate long-term suicide risk.^{264, 266} The person may be helped by learning to regulate

intense emotions, to curb impulsivity, and to build up a meaningful way of life.²⁶⁴ Chronically suicidal people recover when their quality of life improves.

Among people who self-harm, an appropriate response to identified risks is based on frequent review to detect changes in the pattern (including frequency, type and level) of risk (Figure 8.1).²⁶⁶

Figure 8.1 Estimating probable level of suicide risk based on self-harm behaviour



Adapted from Spectrum (personality disorder service for Victoria: www.spectrumbpd.com.au)

Figure 8.1 is a guide to estimating the probable level of risk in a person with BPD who self-harms, by considering the pattern and lethal potential of self-harm. However, risk may change suddenly or be difficult to predict based solely on the signs and symptoms available to the clinician. Frequent review, a trusting therapeutic relationship and helping the person to build a strong support network are necessary to help keep the person safe.

A person who has lived with habitual or persistent low-lethality self-harm over time may be at relatively low immediate risk of suicide (green zone, lower left quadrant in Figure 8.1). However, if that person begins to use potentially lethal methods of self-harm, this may indicate high risk for suicide sustained over the long term (amber zone, upper left quadrant in Figure 8.1). In this circumstance, BPD treatment provided within the community (e.g. a structured psychological therapy) may be more appropriate than admission to a psychiatric acute care facility, given that the person is likely to be at continued high risk over the long-term and may benefit most from building a satisfying way of life and relationships.

If a person assessed as being at long-term low risk begins to show symptoms that are new for them, this may indicate increased risk (amber zone, lower right quadrant in Figure 8.1). An appropriate response would involve closer observation, thorough review to identify and manage co-occurring mental illness, and continued active treatment for BPD, such as a structured psychological therapy. Suicide tends to occur when a person is no longer receiving treatment and has given up on receiving help.²⁶⁶ However, accidental deaths due to self-harm sometimes occur even when a person does not intend to die.²⁶⁶

In a person assessed as being at constant high risk for suicide over a long period (amber zone upper left in Figure 8.1), the appearance of new symptoms, behaviour or emergent co-occurring mental illness may indicate an increase in immediate risk of suicide (red zone, upper right in Figure 8.1). This situation may require a change in the management plan to ensure the person's immediate safety, while continuing BPD treatment and managing co-occurring mental illness to manage long-term risk. Short-term admission to a psychiatric acute care facility may be appropriate to manage acute risk (see Section 6.3).

8.5.3 Crisis management

For a person with BPD, an adverse experience (whether severe or seemingly trivial) may trigger sudden overwhelming emotional distress and psychosocial dysfunction that lasts for days to weeks. While the risk of self-harm is likely to increase during this time, crises do not always represent psychiatric emergencies and may not involve suicidal behaviour.

Any health professional working with people who have BPD may sometimes be contacted by a person with BPD, or their carer, to report that the person has made a suicide attempt, has threatened suicide, has deliberately injured themselves, or feels desperate and cannot cope. An appropriate response (Table 8.5) might help the person's recovery and prevent further harm.

Health professionals should take the person's distress seriously and should respond compassionately, never interpreting the person's behaviour as merely an attempt to gain attention. Health professionals should stay calm and show a supportive, non-judgemental attitude, and avoid expressing shock or anger, even if the person has self-harmed or behaved recklessly. It is appropriate to show empathy and concern for the person's situation, without over-reacting (see Table 8.5).

During the crisis, any health professional who is not the person's main clinician should focus on the 'here and now'. Issues that require more in-depth discussion (e.g. past experiences or relationship problems) can be dealt with more effectively in longer-term treatment by the person's main clinician or another provider who is treating their BPD (e.g. psychiatrist). If more than one staff member will be dealing with the person (e.g. nurses and doctors in an emergency department), the roles of all staff should be clearly explained to the person.

A risk assessment should be conducted at the time of crisis (see Section 8.5.1). Psychiatric assessment should be conducted during the crisis, if possible. Co-occurring mental illnesses such as depression or psychosis, and substance use or withdrawal should be ruled out.

Although some patients may need brief inpatient care, a crisis should not automatically trigger admission to a psychiatric acute care facility. A crisis episode need not always require a review of pharmacotherapy or prompt initiation of new medicines.

If the health professional dealing with the situation is not the person's main clinician, they should find out who normally treats the person for their BPD and contact them to discuss an immediate response and the person's crisis management plan and BPD management plan. The person's family, partner and carers or other social supports should also be contacted.

If a person with BPD expresses suicidal thoughts during a crisis, it cannot be assumed that they are at immediate high risk, because some people with BPD live with persistent thoughts of suicide. Health professionals should avoid taking control to prevent possible suicidal behaviour. Instead, ask the person to tell you if they want help, and to tell you as clearly as possible what they think will help. Assume that the person can use public emergency services in an emergency. On many occasions it may be helpful for the health professional to understand that the person is expressing an internal state, and to respond empathically, rather than initiating a more active intervention such as calling the police or arranging admission to an acute psychiatric inpatient facility.

If risk assessment suggests that the person is at high immediate risk of suicide or potentially lethal self-harm, a more active response may be appropriate (Table 8.6). Even while responding to an immediate threat of suicide, health professionals can engage the person in future treatment. The health professional dealing with the situation should ascertain whether the person is already involved in psychological treatment and, if so, whether they have been taught skills that could be useful in managing their current distress and suicidal thoughts.

In most cases, even when a person with BPD is suicidal, it will be possible to reach an agreement with the person about their care. The fact that the person has disclosed intent suggests a degree of motivation to seek help.

After the crisis, a follow-up appointment should be made and the person should be referred to other appropriate services as necessary. All services should set up a process for ensuring that anyone who is seen during a crisis attends their follow-up appointment, whether the follow-up consultation is arranged within that service or in a specialised referral service.

Health professionals who deal with a person with BPD during a crisis are liable to experience strong emotions including concern, anxiety, frustration and anger. It is helpful to acknowledge such feelings as a normal response and to seek support or supervision from colleagues.

Table 8.5 Principles of response to a BPD crisis

During a crisis

- Respond to the crisis promptly, whether reported by the person or by a family member or carer.
- Listen to the person – use an interviewing style that validates the person's experience and shows that you believe the person's distress is real. Let the person 'ventilate' – this can relieve tension.
- Be supportive, non-judgemental, and show empathy and concern. Express concern if the person mentions suicidal thoughts or other risks to their safety.
- Assess the person's risk. Check if there is any change in the pattern of self-harm and suicidality that could indicate high immediate risk. Check for repeated traumatic experiences or new adverse life events.
- Assess psychiatric status and rule out co-occurring mental illness.
- Stay calm and avoid expressing shock or anger.
- Focus on the here and now.
- Take a problem-solving approach.
- Plan for the person's safety in collaboration with them. Do not assume that you know best about how to help them during a crisis. Ask the person to say if they want help and to explain what kind of help they would like. Provide practical help.
- Clearly explain your role and the roles of other staff members.
- Communicate with and involve the person's family, partner or carers, if appropriate.
- Offer support to the person's family, partner or carers.
- Refer the person to other services, as appropriate, and make a follow-up appointment.
- Consider offering brief admission to an acute psychiatric inpatient facility if the person has presented to an emergency department and is at significant immediate risk of harm, or if the person has a co-occurring mental illness (e.g. depression or substance use disorder).
- Where possible, liaise with other clinicians/teams/hospitals involved in the person's care. These should be identified in the person's management plan and crisis plan (if available).

After a crisis

- Follow up by discussing all safety issues, including their effect on you, within the context of scheduled appointments.
- Actively interpret the factors that might have helped provide relief (e.g. the perception of being cared for).
- Explain that it is not feasible to depend on the mental health service or GP to be available at all times. Help the person use a problem-solving approach to identify practical alternatives in a crisis.
- Help the person deal with their anger whenever it becomes apparent.

Adapted from Project Air Strategy *Treatment guidelines for personality disorder* (2011)¹⁸² (available at www.projectairstrategy.org) and Gunderson JG, Links PS. *Borderline personality disorder: a clinical guide*. 2nd ed (2008)¹⁹⁷

Table 8.6 What to do if a person with BPD is at high acute risk of suicide

- Do not leave the person alone. If necessary, use the powers of local mental health legislation.
- Prevent or reduce access to the means of suicide.
- Do not use threats or try to make the person feel guilty.
- Consult senior staff.
- Contact all involved in the person's care (e.g. medical practitioner, crisis team, mental health service, hospital, family, partner, carers, other supports).
- Find out what, or who, has helped in the past.
- Clearly explain your actions.
- Do not agree to keep the suicide plan a secret.
- Make a management plan.
- Consider whether brief admission to a psychiatric inpatient service is needed.

Adapted from Project Air Strategy *Treatment guidelines for personality disorder*¹⁸²
(available at www.projectairstrategy.org)

9. Areas for future research

The body of evidence about borderline personality disorder (BPD) is limited in both scope and scale. While assessing evidence informing the prevention, diagnosis and clinical management of BPD, the Committee identified several areas in which further research is needed, including the following.

9.1 Risk Factors and prevention

Identifying modifiable risk factors

BPD prevention

9.2 Identifying and assessing BPD

Defining BPD

Treatment outcome priorities for people with BPD

The impact of cultural influences on BPD

Suicide rates among people with BPD in Australia

Prevalence of BPD in Australia

Identifying late-onset BPD in older adults

9.3 Managing BPD

Brief interventions for BPD

Alternative modes for delivering BPD psychoeducation and therapy

Defining 'recovery' from BPD

Mechanisms of change in structured psychological therapy

Development of effective crisis interventions

Needs, treatment options and services for men with BPD

Needs, treatment options and services for older people with BPD

Managing psychotic symptoms in people with BPD

9.4 Organising services

Needs, treatment options and services for Aboriginal and Torres Strait Islander peoples with BPD

Needs, treatment options and services for people from cultural and demographic groups not included in current research

Needs, treatment options and services for people with 'mild' BPD

Carer and consumer perspectives on service delivery

The effectiveness of specific therapies for BPD in the various settings of the Australian healthcare system

Support, psychoeducation and supervision of staff who manage people with BPD

Stigma

Treatment pathways and models of care

Cost-effectiveness of BPD treatments

9.5 Supporting families, partners and carers

The role of families in recovery

Effective and appropriate programs to support carers, including young carers, of people with BPD

Psychological, social and developmental effects on children who have a parent with BPD

Interventions targeted at mothers with BPD to improve parent-child relationships and improve psychological, social and developmental outcomes for children

10. Templates and resources

10.1 Borderline personality disorder (BPD) management plan template

Personal details

Name:	Date of birth:
Address:	
Phone:	
Family member's/partner's/carer's contact details:	
Date:	Next review date:

Health professionals involved in treatment

Name	Contact details	Role	Alternative contact person	Contact for alternative	Copy of this plan received (✓/x)

Case summary

Brief history:
Diagnosis:
Current living arrangements and social circumstances:

Risk assessment

Risk to self
Acute suicide risk:
Long-term patterns of self-injurious acts
High-lethality behaviours:
Low-lethality behaviours:
Other risks:
Risks to other people
Risks to property

Treatment goals

Short-term treatment goals:
Long-term treatment goals:

Current psychosocial treatment

Approach	Commencement date	Planned review date	Provider/s

Medicines*Current medicines (if any)*

Name of medicine	Dosing information	Purpose

Medicines previously unsuccessful in a therapeutic trial:

Cautions (e.g. medicines associated with overdose):

Health professional primarily responsible for prescribing and reviewing medicines:

Management of self-harm during office hours

--

Management of self-harm outside office hours

If person calls before self-harm has occurred (chronic pattern):

If person calls after self-harm has occurred (chronic pattern):

Agreed responses to specific presentations

Presentation	Response	Notes

Indicators for reviewing treatment plan

Indicators of increased risk related to self-harm/suicidality behaviour patterns:

Other possible indicators of increased risk:

Emergency department treatment plan (if applicable)

Usual clinical presentations:
Indications for hospital admission:
Predicted appropriate length of admission:
Discharge planning notes:

Inpatient treatment plan (if applicable)

Indications for admission:
Predicted appropriate length of admission:
What to do if person self-harms during admission:
What to do if person found to be under the influence of substances while admitted:
What to do if person expresses suicidal thoughts at the time of a planned discharge:

Rationale for interventions and strategies

Clinical interventions/responses that have been helpful in the past:

Situation	Intervention or response	Outcome	Notes

Clinical interventions/responses that have been unhelpful in the past:

Situation	Intervention or response	Outcome	Notes

Coping/management strategies used by the person:

Situation/problem	Strategy/action	Successful (yes/no)	Notes

Signatures

Clinician:
Client (if appropriate and willing):
Family/Partner/Carer (if client is willing):

Adapted from Spectrum (BPD service for the state of Victoria)¹⁶²

Explanatory notes

Health professionals involved in treatment: Clearly describe the role of each health professional in the person's treatment, including the frequency of contact with the person. For each health professional listed, the name and contact details of one or more alternative health professional should be provided. List health professionals from all services involved in the person's care, including the person's usual GP.

Risk assessment: Outline the patterns of chronic self-injurious behaviours and acute suicide risk situations and any other risks (sexual, financial, driving, substance intoxications, etc.). The description of chronic acts of self-injury should differentiate high- and low-lethality behaviours (relatively low-lethality self-injurious acts such as superficial cutting and burning, minor overdoses should be differentiated from high-lethality behaviours such as taking massive overdoses, self-asphyxiation by hanging, carbon monoxide poisoning, etc.).

For each self-harm pattern, provide information about the period typically leading to self-harm, including the usual sequences of thoughts, feelings and actions and any observable signs.

Record any risk of accidental death by misadventure.

List factors/situations that are likely to contribute to acute risk of suicide (e.g. loss of relationships, disappointments, contact with particular people who the person associates with abuse).

Where possible, specify the relationship of self-harm acts to the meaning they have for the person (e.g. overdosing on prescribed medicines or hanging after calling for help may be associated with relief from emotional pain; Superficial cutting may be associated with abandonment anxiety; Driving recklessly, starving, bingeing and purging might be associated with relief from cognitive pain; Deep lacerations done in secret after an overdose on paracetamol and under influence of alcohol may be associated with intent to die).

Treatment goals: Examples of short-term goals include keeping the person alive, reducing self-harm acts, reducing need for hospitalisations, improving therapeutic engagement, reducing substance use, etc. Examples of long-term treatment goals include transferring the person to another health service for long-term psychotherapy, achieving clinical remission, functional recovery, etc.

Interventions/strategies that have helped in the past: List helpful and unhelpful interventions/strategies with examples for each crisis or self-harm pattern, including presentations to all services involved (e.g. emergency department, general practice, acute psychiatric inpatient facility, usual mental health service provider). The person's inputs are very important in completing this section. Specifically mention the responses that the person considered to be invalidating.

Possible indicators of risk outside the self-harm/suicidality risk behaviour patterns: Include individual risk indicators e.g. psychosis, major depression, etc.

Agreed responses to specific presentations: Record agreed actions to be followed in specific circumstances (e.g. presentation with substance intoxications, presentation following self-harm) as negotiated with the person.

10.2 BPD crisis management plan template

Personal details

Name:	Date of birth:
Address:	
Family/partner/carer's contact details:	
Health professionals involved in the person's care:	

Date of plan:

--

Clinical notes

Diagnostic statement:
Brief clinical summary:
Developmental history:
Triggers for self-harm or suicidal behaviours:

Description of crisis pattern from past history

Duration:
Frequency:
Triggers:
Behaviour during crisis:

Safety concerns during a crisis

Self-harm behaviour during crisis:
Suicidal behaviour during crisis:
Safety concerns for others and property:

Management strategies during a crisis

Who the person should contact in a crisis within office hours:
Who the person should contact in a crisis outside office hours:
Planned response:

Strategy	Notes

Notes for specific health services:

Service	Notes
Emergency department	
GP	

Admission to acute psychiatric facility

Indications for admission:
Brief voluntary admissions have been negotiated with the person (Yes/No):

Rationale for management strategy

Person's suggestions for what may help:

Clinical interventions/responses that have helped in the past

Situation	Intervention or response	Outcome	Notes

Clinical interventions/responses that have been unhelpful in the past

Situation	Intervention or response	Outcome	Notes

Person's own copy of crisis plan

Copy received (✓/ X):	Copy of separate version attached (✓/ X):
Treating Clinician:	
Patient (if willing and able to negotiate the plan):	
Family/Partner/Carer: (if client is willing)	

Signatures

Clinician:
Client (if appropriate and willing):
Family/Partner/Carer (if client is willing):

Adapted from Spectrum (BPD service for the state of Victoria)¹⁶²

Explanatory notes

Clinical notes: The developmental history should be aimed at eliciting empathy in care providers. Triggers for self-harm or suicidal behaviours should include an empathic account of the person's usual reasons for self-injurious behaviours.

11. Clinical questions

The clinical questions on which the recommendations are based are listed below.

Italics indicates a new question formulated by the Committee. All other clinical questions were previously addressed in the UK national BPD clinical practice guideline.¹

Additional literature searches were conducted to identify studies involving Aboriginal and Torres Strait Islander people with BPD, and for evidence on cost-effectiveness of BPD management strategies.

11.1 Identifying and assessing BPD

1. What can help clinicians identify features of BPD in young people?
2. Are there tools/assessments that could be used?

11.2 Managing risk factors and preventing BPD

3. *What are the risk factors for BPD?*
4. *What preventative interventions are available to reduce the incidence of BPD? (as a primary or secondary outcome)*

11.3 Managing BPD

5. What interventions and care processes are effective in improving outcomes or altering the developmental course for people aged under 18 years with borderline symptoms or putative BPD? (that is, would meet diagnosis if over 18)
6. For people with BPD, which treatments are associated with improvement in mental state and quality of life, reduction in self-harm, service use, and risk-related behaviour, and/or improved social and personal functioning while minimising harms?
7. Which psychological therapies are most effective? (CBT, mentalisation, behaviour therapy, psychodynamic, CAT, group therapy, family therapy, schema-focussed therapy, transference-focussed and DBT, miscellaneous)
8. Which psychosocial therapies are most effective?^{2ah}
9. Which pharmacological therapies maximise benefits while minimising harms? (+ comorbidities)
10. *Among people with BPD are multimodal therapies (pharmacological, psychological, team approaches, day programs, inpatient programs, family/systems therapies, therapeutic communities) more effective than single modal therapies in reducing suicide/self-harm, psychopathology and increasing functioning?*

ah The Committee determined to merge questions 7 and 8 into a single question: *Which psychological or psychosocial therapies are most effective?*

11. *Among people with BPD and comorbidities (medical [HIV/AIDS, diabetes, chronic pain, obesity, chronic fatigue], other personality disorders, other mental health, alcohol and drug disorders, eating disorders, intellectual disability) what treatments are effective in reducing suicide/self-harm, psychopathology and increasing functioning?*
12. How should complex and severe BPD be managed, including management strategies (over a period of time) and multiple comorbidities?^{2ai}
13. How should the treatment of common comorbidities (depression, psychosis, anxiety disorders, bipolar disorder, substance use disorder, other axis II disorders) be altered in the presence of BPD?
14. *Among people with BPD what treatment modes of delivery are most effective in reducing suicide/self-harm, psychopathology, increasing functioning? (face-to-face, group, online, self-help)*

11.4 Organising healthcare services to meet the needs of people with BPD

15. What type of services maximise effectiveness and safety and minimise harm (taking into account long-term outcomes) for the delivery of specific treatments for people with BPD? (for example, day hospitals, inpatient, therapeutic communities, use of enhanced care programming, team-based or individual-based care, partial hospitalisation)
16. What is the role of inpatient (e.g. acute, forensic) care in the management of people with BPD?
17. What is the role of specialist services (including community-based) in the medium and long term management of people with BPD?
18. Is long-term inpatient care in the treatment of BPD effective?
19. Are particular therapies suited for particular service settings?
20. How should healthcare professionals from other healthcare settings care for people with BPD? (primary care, accident and emergency, crisis services, crisis houses, acute care)
21. Which treatment pathways, care processes and clinical principles (case management, care coordination, care programme approach and so on) maximise the effectiveness of care and reduce harm?
22. How can healthcare professionals involved in the care of people with BPD best be supported? (supervision, training, caseloads and so on)

11.5 Supporting families and carers

23. Do families (including children) and families/carers of people with BPD have specific care needs?
24. If so, what specific interventions should be offered?
25. Do family or carers, through their behaviour, styles of relating and relationships, influence clinical and social outcomes or wellbeing for people with BPD?
26. If so, what interventions should be offered?

ai Systematic literature review was not undertaken for this question (see Section 1.7.4)

References

1. National Collaborating Centre for Mental Health. Borderline personality disorder: treatment and management. National clinical practice guideline number 78. Leicester: The British Psychological Society and The Royal College of Psychiatrists; 2009.
2. National Health and Medical Research Council. Levels of evidence and grades for recommendations for developers of guidelines. Canberra: NMRC; 2009.
3. Tyrer P, Jones V, Thompson S, Catalan J, Schmidt U, Davidson K, Knapp M, Ukoumunne OC; POPMACT group. Service variation in baseline variables and prediction of risk in a randomised controlled trial of psychological treatment in repeated parasuicide: the POPMACT Study. *Int J Soc Psychiatry* 2003; 49: 58–69.
4. Weinberg I, Gunderson JG, Hennen J, Cutter CJ. Manual assisted cognitive treatment for deliberate self-harm in borderline personality disorder patients. *J Pers Disord* 2006; 20: 482–492.
5. Blum N, St John D, Pfohl B, Stuart S, McCormick B, Allen J, Arndt S, Black DW. Systems Training for Emotional Predictability and Problem Solving (STEPPS) for outpatients with borderline personality disorder: a randomized controlled trial and 1-year follow-up. *Am J Psychiatry* 2008; 165: 468–478.
6. Chanen AM, Jackson HJ, McCutcheon LK, Jovev M, Dudgeon P, Yuen HP, Germano D, Nistico H, McDougall E, Weinstein C, Clarkson V, McGorry PD. Early intervention for adolescents with borderline personality disorder using cognitive analytic therapy: randomised controlled trial. *Br J Psychiatry* 2008; 193: 477–484.
7. Clarkin JF, Levy KN, Lenzenweger MF, Kernberg OF. The Personality Disorders Institute/Borderline Personality Disorder Research Foundation randomized control trial for borderline personality disorder: rationale, methods, and patient characteristics. *J Pers Disord* 2004; 18: 52–72.
8. Davidson K, Norrie J, Tyrer P, Gumley A, Tata P, Murray H, Palmer S. The effectiveness of cognitive behaviour therapy for borderline personality disorder: results from the borderline personality disorder study of cognitive therapy (BOSCOT) trial. *J Pers Disord* 2006; 20: 450–465.
9. Giesen-Bloo J, van Dyck R, Spinhoven P, van Tilburg W, Dirksen C, van Asselt T, Kremers I, Nadort M, Arntz A. Outpatient psychotherapy for borderline personality disorder: randomized trial of schema-focused therapy vs transference-focused psychotherapy. *Arch Gen Psychiatry* 2006; 63: 649–658.
10. Munroe-Blum H, Marziali E. A controlled trial of short-term group treatment for borderline personality disorder. *J Pers Disord* 1995; 9: 190–198.
11. Bateman A, Fonagy P. Effectiveness of partial hospitalization in the treatment of borderline personality disorder. *Am J Psychiatry* 1999; 156: 1563–1569.

12. Koons CR, Robins CJ, Tweed JL, Lynch TR, Gonzalez AM, Morse JQ, Bishop KG, Butterfield MI, Bastian LA. Efficacy of dialectical behaviour therapy in women veterans with borderline personality disorder. *Behav Ther* 2001; 32: 371–390.
13. Linehan MM, Armstrong HE, Suarez A, Allmon D, Heard HL. Cognitive-behavioral treatment of chronically parasuicidal borderline patients. *Arch Gen Psychiatry* 1991; 48: 1060–1064.
14. Linehan MM, Comtois KA, Murray AM, Brown MZ, Gallop RJ, Heard HL, Korslund KE, Tutek DA, Reynolds SK, Lindenboim N. Two-year randomized controlled trial and follow-up of dialectical behavior therapy vs therapy by experts for suicidal behaviors and borderline personality disorder. *Arch Gen Psychiatry* 2006; 63: 757–766.
15. Turner RM. Naturalistic evaluation of dialectical behavior therapy-oriented treatment for borderline personality disorder. *Cogn Behav Pract* 2000; 7: 413–419.
16. van den Bosch LM, Verheul R, Schippers GM, van den Brink W. Dialectical Behavior Therapy of borderline patients with and without substance use problems. Implementation and longterm effects. *Addict Behav* 2002; 27.
17. Carter G. Hunter Dialectical Behaviour Therapy Project. Unpublished report [Cited in National Collaborating Centre for Mental Health. Borderline personality disorder: treatment and management. National clinical practice guideline number 78. Leicester: The British Psychological Society and The Royal College of Psychiatrists; 2009]. 2008.
18. 18. Barnicot K, Katsakou C, Marougka S, Priebe S. Treatment completion in psychotherapy for borderline personality disorder: a systematic review and meta-analysis. *Acta Psychiatr Scand* 2011; 123: 327–338.
19. 19. Carter GL, Willcox CH, Lewin TJ, Conrad AM, Bendit N. Hunter DBT project: Randomized controlled trial of dialectical behaviour therapy in women with borderline personality disorder. *Aust N Z J Psychiatry* 2010; 44: 162–173.
20. 20. Harned MS, Chapman AL, Dexter-Mazza ET, Murray A, Comtois KA, Linehan MM. Treating co-occurring axis I disorders in recurrently suicidal women with borderline personality disorder: A 2-year randomized trial of dialectical behavior therapy versus community treatment by experts. *J Consult Clin Psychol* 2008; 76: 1068–1075.
21. 21. McMain SF, Links PS, Gnam WH, Guimond T, Cardish RJ, Korman L, Streiner DL. A randomized trial of dialectical behavior therapy versus general psychiatric management for borderline personality disorder. *Am J Psychiatry* 2009; 166: 1365–1374.
22. Soler J, Pascual JC, Tiana T, Cebrià A, Barrachina J, Campins MJ, Gich I, Alvarez E, Pérez V. Dialectical behaviour therapy skills training compared to standard group therapy in borderline personality disorder: a 3-month randomised controlled clinical trial. *Behav Res Ther* 2009; 47: 353–358.
23. Ball SA, Maccarelli LM, LaPaglia DM, Ostrowski MJ. Randomized trial of dual-focused vs. single-focused individual therapy for personality disorders and substance dependence. *J Nerv Ment Dis* 2011; 199: 319–328.
24. Rowe SL, Jordan J, McIntosh VV, Carter FA, Bulik CM, Joyce PR. Impact of borderline personality disorder on bulimia nervosa. *Aust N Z J Psychiatry* 2008; 42: 1021–1029.

25. Davidson KM, Tyrer P, Norrie J, Palmer SJ, Tyrer H. Cognitive therapy v. usual treatment for borderline personality disorder: prospective 6-year follow-up. *Br J Psychiatry* 2010; 197: 456–462.
26. Bateman A, Fonagy P. 8-year follow-up of patients treated for borderline personality disorder: mentalization-based treatment versus treatment as usual. *Am J Psychiatry* 2008; 165: 631–638.
27. Bateman A, Fonagy P. Randomized controlled trial of outpatient mentalization-based treatment versus structured clinical management for borderline personality disorder. *Am J Psychiatry* 2009; 166: 1355–1364.
28. Bos EH, Van Wel EB, Appelo MT, Verbraak MJPM. A randomized controlled trial of a Dutch version of systems training for emotional predictability and problem solving for borderline personality disorder. *J Nerv Ment Dis* 2010; 198: 299–304.
29. Schuppert H, Giesen-Bloo J, van Gemert TG, Wiersema HM, Minderaa RB, Emmelkamp PM, Nauta MH. Effectiveness of an emotion regulation group training for adolescents—a randomized controlled pilot study. *Clin Psychol Psychother* 2009; 16: 467–478.
30. Bellino S, Rinaldi C, Bogetto F. Adaptation of interpersonal psychotherapy to borderline personality disorder: a comparison of combined therapy and single pharmacotherapy. *Can J Psychiatry* 2010; 55: 74–81.
31. Bellino S, Zizza M, Camilla R, Filippo B. Combined treatment of major depression in patients with borderline personality disorder: a comparison with pharmacotherapy. *Can J Psychiatry* 2006; 51: 453–460.
32. Doering S, Horz S, Rentrop M, Fischer-Kern M, Schuster P, Benecke C, Buchheim A, Martius P, Buchheim P. Transference-focused psychotherapy v. treatment by community psychotherapists for borderline personality disorder: randomised controlled trial. *Br J Psychiatry* 2010; 196: 389–395.
33. Morey LC, Lowmaster SE, Hopwood CJ. A pilot study of manual-assisted cognitive therapy with a therapeutic assessment augmentation for borderline personality disorder. *Psychiatry Res* 2010; 178: 531–535.
34. Gregory RJ, DeLucia-Deranja E, Mogle JA. Dynamic deconstructive psychotherapy versus optimized community care for borderline personality disorder co-occurring with alcohol use disorders: a 30-month follow-up. *J Nerv Ment Dis* 2010; 198: 292–298.
35. Gregory RJ, Remen AL, Soderberg M, Ploutz-Snyder RJ. A controlled trial of psychodynamic psychotherapy for co-occurring borderline personality disorder and alcohol use disorder: six-month outcome. *J Am Psychoanal Assoc* 2009; 57: 199–205.
36. Kramer U, Berger T, Kolly S, Marquet P, Preisig M, de Roten Y, Despland JN, Caspar F. Effects of motive-oriented therapeutic relationship in early-phase treatment of borderline personality disorder: a pilot study of a randomized trial. *J Nerv Ment Dis* 2011; 199: 244–250.

37. Zanarini MC, Frankenburg FR. A preliminary, randomized trial of psychoeducation for women with borderline personality disorder. *J Pers Disord* 2008; 22: 284-290.
38. Cottraux J, Note ID, Boutitie F, Milliery M, Genouihlac V, Yao SN, Note B, Mollard E, Bonasse F, Gaillard S, Djamoossian D, Guillard Cde M, Culem A, Gueyffier F. Cognitive therapy versus Rogerian supportive therapy in borderline personality disorder. Two-year follow-up of a controlled pilot study. *Psychother Psychosom* 2009; 78: 307-316.
39. Farrell JM, Shaw IA, Webber MA. A schema-focused approach to group psychotherapy for outpatients with borderline personality disorder: a randomized controlled trial. *J Behav Ther Exp Psychiatry* 2009; 40: 317-328.
40. Harned MS, Jackson SC, Comtois KA, Linehan MM. Dialectical behavior therapy as a precursor to PTSD treatment for suicidal and/or self-injuring women with borderline personality disorder. *J Trauma Stress* 2010; 23: 421-429.
41. de la Fuente JM, Lotstra F. A trial of carbamazepine in borderline personality disorder. *Eur Neuropsychopharmacol* 1994; 4: 479-486.
42. Frankenburg FR, Zanarini MC. Divalproex sodium treatment of women with borderline personality disorder and bipolar II disorder: a double-blind placebo-controlled pilot study. *J Clin Psychiatry* 2002; 63: 442-226.
43. Hollander E, Allen A, Lopez RP, Bienstock CA, Grossman R, Siever LJ, Merkat L, Stein DJ. A preliminary double-blind, placebo-controlled trial of divalproex sodium in borderline personality disorder. *J Clin Psychiatry* 2001; 62: 199-203.
44. Hollander E, Tracy KA, Swann AC, Coccaro EF, McElroy SL, Wozniak P, Sommerville KW, Nemeroff CB. Divalproex in the treatment of impulsive aggression: efficacy in cluster B personality disorders. *Neuropsychopharmacology* 2003; 28: 1186-1197.
45. Loew TH, Nickel MK, Muehlbacher M, Kaplan P, Nickel C, Kettler C, Fartacek R, Lahmann C, Buschmann W, Tritt K, Bachler E, Mitterlehner F, Pedrosa Gil F, Leiberich P, Rother WK, Egger C. Topiramate treatment for women with borderline personality disorder: a double-blind, placebo-controlled study. *J Clin Psychopharmacol* 2006; 26: 61-66.
46. Nickel MK, Nickel C, Mitterlehner FO, Tritt K, Lahmann C, Leiberich PK, Rother WK, Loew TH. Topiramate treatment of aggression in female borderline personality disorder patients: a double-blind, placebo controlled study. *J Clin Psychiatry* 2004; 65: 1515-1519.
47. Nickel MK, Nickel C, Kaplan P, Lahmann C, Muehlbacher M, Tritt K, Krawczyk J, Leiberich PK, Rother WK, Loew TH. Treatment of aggression with topiramate in male borderline patients: a double-blind, placebo-controlled study. *Biol Psychiatry* 2005; 57: 495-499.
48. Tritt K, Nickel C, Lahmann C, Leiberich PK, Rother WK, Loew TH, Nickel MK. Lamotrigine treatment of aggression in female borderline-patients: a randomized, double-blind, placebo-controlled study. *J Psychopharmacol* 2005; 19: 287-291.
49. Rinne T, van den Brink W, Wouters L, van Dyck R. SSRI treatment of borderline personality disorder: a randomized, placebo-controlled clinical trial for female patients with borderline personality disorder. *Am J Psychiatry* 2002; 159: 2048-2054.

50. Simpson B, Yen S, Costello E, Rosen K, Begin A, Pistorello J, Pearlstein T. Combined dialectical behavior therapy and fluoxetine in the treatment of borderline personality disorder. *J Clin Psychiatry* 2004; 65: 379-385.
51. Bellino S, Zizza M, Rinaldi C, Bogetto F. Combined therapy of major depression with concomitant borderline personality disorder: comparison of interpersonal and cognitive psychotherapy. *Can J Psychiatry* 2007; 52: 718-725.
52. Soloff PH, George A, Nathan S, Schulz PM, Cornelius JR, Herring J, Perel JM. Amitriptyline versus haloperidol in borderlines: final outcomes and predictors of response. *J Clin Psychopharmacol* 1989; 9: 238-246.
53. Soloff PH, Cornelius J, George A, Nathan S, Perel JM, Ulrich RF. Efficacy of phenelzine and haloperidol in borderline personality disorder. *Arch Gen Psychiatry* 1993; 50: 377-385.
54. Bogenschutz M, George Nurnberg H. Olanzapine versus placebo in the treatment of borderline personality disorder. *J Clin Psychiatry* 2004; 65: 104-109.
55. Eli Lilly. Efficacy and safety of olanzapine in patients with borderline personality disorder: a randomized double-blind comparison with placebo. Trial number 6253. [Unpublished. Cited in National Collaborating Centre for Mental Health. Borderline personality disorder: treatment and management. National clinical practice guideline number 78. Leicester: The British Psychological Society and The Royal College of Psychiatrists; 2009.].
56. Zanarini MC, Frankenburg FR. Olanzapine treatment of female borderline personality disorder patients: a double-blind, placebo-controlled pilot study. *J Clin Psychiatry* 2001; 62: 849-854.
57. Schulz SC, Zanarini MC, Bateman A, Bohus M, Detke HC, Trzaskoma Q, Tanaka Y, Lin D, Deberdt W, Corya S. Olanzapine for the treatment of borderline personality disorder: variable dose 12-week randomised double-blind placebo controlled study. *Br J Psychiatry* 2008; 193: 485-492.
58. Soler J, Pascual JC, Campins J, Barrachina J, Puigdemont D, Alvarez E, Pérez V. Double-blind, placebo-controlled study of dialectical behavior therapy plus olanzapine for borderline personality disorder. *Am J Psychiatry* 2005; 162: 1221-1224.
59. Nickel MK, Muehlbacher M, Nickel C, Kettler C, Pedrosa Gil F, Bachler E, Buschmann W, Rother N, Fartacek R, Egger C, Anvar J, Rother WK, Loew TH, Kaplan P. Aripiprazole in the treatment of patients with borderline personality disorder: a double-blind, placebo-controlled study. *Am J Psychiatry* 2006; 163: 833-838.
60. Pascual JC, Soler J, Puigdemont D, Pérez-Egea R, Tiana T, Pérez V. Ziprasidone in the treatment of borderline personality disorder: a double-blind, placebo-controlled, randomized study. *J Clin Psychiatry* 2008; 69: 603-608.
61. Leone NF. Response of borderline patients to loxapine and chlorpromazine. *J Clin Psychiatry* 1982; 43: 148-159.
62. Hallahan B, Hibbeln JR, Davis JM, Garland MR. Omega-3 fatty acid supplementation in patients with recurrent self-harm. Single-centre double-blind randomised controlled trial. *Br J Psychiatry* 2007; 190: 118-122.

63. Zanarini MC, Frankenburg FR. Omega-3 Fatty acid treatment of women with borderline personality disorder: a double-blind, placebo-controlled pilot study. *Am J Psychiatry* 2003; 160: 167-169.
64. Bellino S, Paradiso E, Bogetto F. Efficacy and tolerability of pharmacotherapies for borderline personality disorder. *CNS Drugs* 2008; 22: 671-692.
65. Duggan C, Huband N, Smailagic N, Ferriter M, Adams C. The use of pharmacological treatments for people with personality disorder: A systematic review of randomized controlled trials. *Personal Ment Health* 2008; 2: 207-217.
66. Ingenhoven T, Lafay P, Rinne T, Passchier J, Duivenvoorden H. Effectiveness of pharmacotherapy for severe personality disorders: meta-analyses of randomized controlled trials. *J Clin Psychiatry* 2010; 71: 14-25.
67. Lieb K, Völm B, Rucker G, Timmer A, Stoffers JM. Pharmacotherapy for borderline personality disorder: Cochrane systematic review of randomised trials. *Br J Psychiatry* 2010; 196: 4-12.
68. Mercer D, Douglass AB, Links PS. Metaanalyses of mood stabilizers, antidepressants and antipsychotics in the treatment of borderline personality disorder: effectiveness for depression and anger symptoms. *J Personal Disord* 2009; 23: 156-174.
69. Stoffers J, Völm BA, Rucker G, Timmer A, Huband N, Lieb K. Pharmacological interventions for borderline personality disorder. *Cochrane Database Syst Rev* 2010; Issue 6.
70. Varghese BS, Rajeev A, Norrish M, Khusaiby SB. Topiramate for anger control: a systematic review. *Indian J Pharmacol* 2010; 42: 135-141.
71. Leiberich P, Nickel MK, Tritt K, Pedrosa Gil F. Lamotrigine treatment of aggression in female borderline patients, Part II: an 18-month follow-up. *J Psychopharmacol* 2008; 22: 805-808.
72. Loew TH, Nickel MK. Topiramate treatment of women with borderline personality disorder, part II: an open 18-month follow-up. *J Clin Psychopharmacol* 2008; 28: 355-357.
73. Shafti SS, Shahveisi B. Olanzapine versus haloperidol in the management of borderline personality disorder: a randomized double-blind trial. *J Clin Psychopharmacol* 2010; 30: 44-47.
74. Ziegenhorn AA, Roepke S, Schommer NC, Merkl A, Danker-Hopfe H, Perchel FH, Heuser I, Anghelescu IG, Lammers CH. Clonidine improves hyperarousal in borderline personality disorder with or without comorbid post-traumatic stress disorder: a randomized, double-blind, placebo-controlled trial. *J Clin Psychopharmacol* 2009; 29: 170-173.
75. Bohus M, Haaf B, Simms T, Limberger MF, Schmahl C, Unckel C, Lieb K, Linehan MM. Effectiveness of inpatient dialectical behavioral therapy for borderline personality disorder: a controlled trial. *Behav Res Ther* 2004; 42: 487-499.
76. Chanen AM, Jackson HJ, McCutcheon LK, Jovev M, Dudgeon P, Yuen HP, Germano D, Nitico H, McDougall E, Weinstein C, Clarkson V, McGorry PD. Early intervention for adolescents with borderline personality disorder: quasi-experimental comparison with treatment as usual. *Aust N Z J Psychiatry* 2009; 45: 397-408.

77. Berrino A, Ohlendorf P, Duriaux S, Burnand Y, Lorillard S, Andreoli A. Crisis intervention at the general hospital: an appropriate treatment choice for acutely suicidal borderline patients. *Psychiatry Res* 2011; 186: 287-292.
78. Leichsenring F, Leibing E, Kruse J, New AS, Leweke F. Borderline personality disorder. *Lancet* 2011; 377: 74-84.
79. American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 4th edition, Text Revision (DSM-IV-TR). Washington DC: American Psychiatric Association; 2000.
80. Chanen AM, McCutcheon LK, Jovev M, Jackson HJ, McGorry PD. Prevention and early intervention for borderline personality disorder. *Med J Aust* 2007; 187: S18-S21.
81. Kernberg O, Michels R. Borderline Personality Disorder. *Am J Psychiatry* 2009; 166: 505-508.
82. Pompili M, Girardi P, Ruberto A, Tatarelli R. Suicide in borderline personality disorder: a meta-analysis. *Nord J Psychiatry* 2005; 59: 319-324.
83. Zanarini MC, Frankenburg FR, Hennen J, Reich DB, Silk KR. The McLean Study of Adult Development (MSAD): overview and implications of the first six years of prospective follow-up. *J Pers Disord* 2005; 19: 505-523.
84. Zanarini MC, Frankenburg FR, Hennen J, Reich DB, Silk KR. Prediction of the 10-year course of borderline personality disorder. *Am J Psychiatry* 2006; 163: 827-832.
85. Gunderson JG. Borderline personality disorder: ontogeny of a diagnosis. *Am J Psychiatry* 2009; 166: 530-539.
86. Gunderson JG, Stout RL, McGlashan TH, Shea MT, Morey LC, Grilo CM, Zanarini MC, Yen S, Markowitz JC, Sanislow C, Ansell E, Pinto A, Skodol AE. Ten-year course of borderline personality disorder: psychopathology and function from the Collaborative Longitudinal Personality Disorders Study. *Arch Gen Psychiatry* 2011; 68: 827-837.
87. Zanarini MC, Frankenburg FR, Reich DB, Fitzmaurice G. Time to attainment of recovery from borderline personality disorder and stability of recovery: A 10-year prospective follow-up study. *Am J Psychiatry* 2010; 167: 663-667.
88. Zanarini MC, Frankenburg FR, Reich DB, Fitzmaurice G. Attainment and stability of sustained symptomatic remission and recovery among patients with borderline personality disorder and axis II comparison subjects: a 16-year prospective follow-up study. *Am J Psychiatry* 2012; 169: 476-483.
89. Torgersen S, Kringlen E, Cramer V. The prevalence of personality disorders in a community sample. *Arch Gen Psychiatry* 2001; 58: 590-596.
90. Samuels J, Eaton WW, Bienvenu OJ, Brown CH, Costa PT, Nestadt G. Prevalence and correlates of personality disorders in a community sample. *Br J Psychiatry* 2002; 180: 536-542.
91. Lenzenweger M, Lane M, Loranger A, Kessler R. DSM-IV personality disorders in the National Comorbidity Survey Replication. *Biol Psychiatry* 2007; 62: 553-564.

92. Trull TJ, Jahng S, Tomko RL, Wood PK, Sher KJ. Revised NESARC personality disorder diagnoses: gender, prevalence, and comorbidity with substance dependence disorders. *J Pers Disord* 2010; 24: 412-426.
93. Moran P, Coffey C, Mann A, Carlin J, Patton G. Personality and substance use disorders in young adults. *Br J Psychiatry* 2006; 188: 374-379.
94. Coid J, Yang M, Tyrer P, Roberts A, Ullrich S. Prevalence and correlates of personality disorder in Great Britain. *Br J Psychiatry* 2006; 188: 423-431.
95. Crawford TN, Cohen P, Johnson JG, Kasen S, First MB, Gordon K, Brook JS. Self-reported personality disorder in the Children in the Community sample: convergent and prospective validity in late adolescence and adulthood. *J Pers Disord* 2005; 19: 30-52.
96. Fabrega H, Ulrich R, Pilkonis P, Mezzich J. Personality disorders diagnosed at intake at a public psychiatric facility. *Hosp Community Psychiatry* 1993; 44: 159-162.
97. Kass F, Skodol AE, Charles E, Spitzer RL, Williams JB. Scaled ratings of DSM-III personality disorders. *Am J Psychiatry* 1985; 142.
98. Oldham JM, Skodol AE. Personality disorders in the public sector. *Hosp Community Psychiatry* 1991; 42: 481-487.
99. Zimmerman M, Chelminski I, Young D. The frequency of personality disorders in psychiatric patients. *Psychiatr Clin North Am* 2008; 31: 405-420.
100. Korzekwa MI, Dell PF, Links PS, Thabane L, Webb SP. Estimating the prevalence of borderline personality disorder in psychiatric outpatients using a two-phase procedure. *Compr Psychiatry* 2008; 49: 380-386.
101. Molinari V, Ames A, Essa M. Prevalence of personality disorders in two geropsychiatric inpatient units. *J Geriatr Psychiatry Neurol* 1994; 7: 209-215.
102. Kantojärvi L, Veijola J, Läksy K, Jokelainen J, Herva A, Karvonen JT, Kokkonen P, Järvelin MR, Joukamaa M. Comparison of hospital-treated personality disorders and personality disorders in a general population sample. *Nord J Psychiatry* 2004; 58: 357-362.
103. Herpertz S, Steinmeyer EM, Sass H. "Patterns of comorbidity" among DSM-III-R and ICD-10 personality disorders as observed with a new inventory for the assessment of personality disorders. *Eur Arch Psychiatry Clin Neurosci* 1994; 244: 161-169.
104. Dahl AA. Some aspects of the DSM-III personality disorders illustrated by a consecutive sample of hospitalized patients. *Acta Psychiatr Scand Suppl* 1986; 328: 61-67.
105. Marinangeli MG, Butti G, Scinto A, Di Cicco L, Petruzzi C, Daneluzzo E, Rossi A. Patterns of comorbidity among DSM-III-R personality disorders. *Psychopathology* 2000; 33: 69-74.
106. Grilo CM, McGlashan TH, Quinlan DM, Walker ML, Greenfeld D, Edell WS. Frequency of personality disorders in two age cohorts of psychiatric inpatients. *Am J Psychiatry* 1998; 155: 140-142.

107. Johnson JG, Cohen P, Kasen S, Skodol AE, Oldham JM. Cumulative prevalence of personality disorders between adolescence and adulthood. *Acta Psychiatr Scand* 2008; 118: 410-413.
108. Lewinsohn PM, Rohde P, Seeley JR, Klein DN. Axis II psychopathology as a function of Axis I disorders in childhood and adolescence. *J Am Acad Child Adolesc Psychiatry* 1997; 36: 1752-1759.
109. Chabrol H, Montovany A, Chouicha K, Callahan S, Mullet E. Frequency of borderline personality disorder in a sample of French high school students. *Can J Psychiatry* 2001; 46: 847-849.
110. Jackson HJ, Burgess PM. Personality disorders in the community: results from the Australian National Survey of Mental Health and Wellbeing. *Soc Psychiatry Psychiatr Epidemiol* 2000; 35: 531-538.
111. Paris J. Borderline personality disorder. *CMAJ* 2005; 172: 1579-1583.
112. Mental Health Council of Australia, Brain and Mind Institute, Human Rights and Equal Opportunity Commission. Not for service: experiences of injustice and despair in mental health care in Australia. Canberra: Mental Health Council of Australia; 2005.
113. Australian Parliament Senate Select Committee on Mental Health. A national approach to mental health – from crisis to community. First report. Commonwealth of Australia; 2006.
114. Australian Parliament Senate Standing Committee on Community Affairs. Towards recovery: mental health services in Australia Canberra: Commonwealth of Australia; 2008.
115. Mental Health Coordinating Council. The psychological needs of women in the criminal justice system: considerations for management and rehabilitation Lilyfield, NSW: MHCC; 2010.
116. Hurley W, Dunne MP. Psychological distress and psychiatric morbidity in women prisoners. *Aust N Z J Psychiatry* 1991; 25: 461-470.
117. National Health and Medical Research Council. Procedures and requirements for meeting the 2011 NHMRC standard for clinical practice guidelines. NHMRC; 2011.
118. The ADAPTE Collaboration. The ADAPTE process: resource toolkit for guideline adaptation. Version 2.0: Guideline International Network; 2009 [cited August 2012]. Available from: <http://www.g-i-n.net/document-store/adapte-resource-toolkit-guideline-adaptation-version-2/view?searchterm=adapte>.
119. Appraisal of Guidelines for Research and Evaluation (AGREE II) instrument: The AGREE Collaboration; 2010 [cited August 2012]. Available from: <http://www.agreetrust.org/resourcecentre/agree-ii/>.
120. NHMRC levels of evidence and grades for recommendations for developers of guidelines. NHMRC; 2009.
121. Van de Ven AH, Delbecq AL. The effectiveness of Nominal, Delphi, and Interacting Group decision making processes. *The Academy of Management Journal* 1974; 17: 605-621.
122. Grol R, Wensing M, Eccles M. Improving patient care: the implementation of change in clinical practice. Edinburgh: Elsevier; 2005.

123. Prior M, Guerin M, Grimmer-Somers K. The effectiveness of clinical guideline implementation strategies--a synthesis of systematic review findings. *J Eval Clin Pract* 2008; 15: 888-897.
124. Bywood P, Lunnay B, Roche A. Effective dissemination: a systematic review of implementation strategies for the AOD field. Adelaide: National Centre for Education and Training on Addiction; 2008.
125. Stern A. Psychoanalytic investigation and therapy in the border line group of neuroses. *Psychoanal Q* 1938; 7: 467-489.
126. Beatson J. Borderline personality disorder: history of the borderline concept. In: Beatson J, Rao S, Watson C, editors. *Borderline personality disorder: towards effective treatment*. Fitzroy: Victorian Medical Post Graduate Foundation; 2010. p. 2-17.
127. Stone M. Borderline personality disorder: history of the concept. In: Zarinini M, editor. *Borderline personality disorder*. New York: Taylor and Francis; 2005.
128. Knight RP. Borderline states. *Bull Menninger Clin* 1953; 17: 1-12.
129. Kernberg O. Borderline personality organization. *J Am Psychoanal Assoc* 1967; 15: 641-685.
130. Gunderson J, Singer M. Defining borderline patients: an overview. *Am J Psychiatry* 1975; 132: 1-9.
131. Gunderson JG, Phillips KA. A current view of the interface between borderline personality disorder and depression. *Am J Psychiatry* 1991; 148: 967-975.
132. Gunderson JG, Sabo AN. The phenomenological and conceptual interface between borderline personality disorder and PTSD. *Am J Psychiatry* 1993; 150: 19-27.
133. Lewis KL, Grenyer BF. Borderline personality or complex posttraumatic stress disorder? An update on the controversy. *Harv Rev Psychiatry* 2009; 17: 322-328.
134. Akiskal HS. The temperamental borders of affective disorders. *Acta Psychiatrica Scand Suppl* 1994; 379: 32-37.
135. Paris J, Gunderson J, Weinberg I. The interface between borderline personality disorder and bipolar spectrum disorders. *Compr Psychiatry* 2007; 48: 145-154.
136. Spitzer RL, Endicott J, Gibbon M. Crossing the border into borderline personality and borderline schizophrenia. The development of criteria. *Arch Gen Psychiatry* 1979; 36: 17-24.
137. American Psychiatric Association. *Diagnostic and statistical manual of mental disorders, DSM-III*. 3rd ed. Washington DC: American Psychiatric Association; 1980.
138. American Psychiatric Association. *Diagnostic and statistical manual of mental disorders, DSM-IV*. 4th ed. Washington DC: American Psychiatric Association; 1994.
139. World Health Organization. *The ICD-10 classification of mental and behavioural disorders. Clinical descriptions and diagnostic guidelines*. Geneva: WHO; 1992.

140. Torgersen S, Lygren S, Oien P, Skre I, Onstad S, Edvardsen J, Tambs K, Kringlen E. A twin study of personality disorders. *Compr Psychiatry* 2000; 41: 416-425.
141. Reichborn-Kjennerud T. Genetics of personality disorders. *Clin Lab Med* 2010; 30: 893-910.
142. Crowell SE, Beauchaine TP, Linehan MM. A biosocial developmental model of borderline personality: elaborating and extending Linehan's theory. *Psychol Bull* 2009; 135: 495-510.
143. Stanley B, Siever IJ. The interpersonal dimension of borderline personality disorder: toward a neuropeptide model. *Am J Psychiatry* 2010; 167: 24-39.
144. Meares R, Schore A, Melkonian D. Is borderline personality a particularly right hemispheric disorder? A study of P3a using single trial analysis. *Aust N Z J Psychiatry* 2011; 45: 131-139.
145. Silbersweig D, Clarkin JF, Goldstein M, Kernberg OF, Tuescher O, Levy KN, Brendel G, Pan H, Beutel M, Pavony MT, Epstein J, Lenzenweger MF, Thomas KM, Posner MI, Stern E. Failure of frontolimbic inhibitory function in the context of negative emotion in borderline personality disorder. *Am J Psychiatry* 2007; 164: 1832-1841.
146. Fonagy P, Luyten P. A developmental, mentalization-based approach to the understanding and treatment of borderline personality disorder. *Dev Psychopathol* 2009; 21: 1355-1381.
147. Bateman A, Fonagy P. *Psychotherapy for borderline personality disorder: mentalization-based treatment*. Oxford: Oxford University Press; 2004.
148. Meares R, Gerull F, Stevenson K, Korner A. Is self disturbance the core of borderline personality disorder? An outcome study of borderline personality factors. *Aust N Z J Psychiatry* 2011; 45: 214-222.
149. Wilkinson-Ryan T, Westen D. Identity disturbance in borderline personality disorder: an empirical investigation. *Am J Psychiatry* 2000; 157: 528-541.
150. Agrawal HR, Gunderson J, Holmes BM, Lyons-Ruth K. Attachment studies with borderline patients: a review. *Harv Rev Psychiatry* 2004; 12: 94-104.
151. Ball JS, Links PS. Borderline personality disorder and childhood trauma: evidence for a causal relationship. *Curr Psychiatry Rep* 2009; 11: 63-68.
152. Paris J. The nature of borderline personality disorder: multiple dimensions, multiple symptoms, but one category. 2007; 21: 457-473.
153. Zanarini MC, Frankenburg FR, Reich DB, Hennen J, Silk KR. Adult experiences of abuse reported by borderline patients and Axis II comparison subjects over six years of prospective follow-up. *J Nerv Ment Dis* 2005; 193: 412-416.
154. Cohen P, Crawford TN, Johnson JG, Kasen S. The children in the community study of developmental course of personality disorder. *J Pers Disord* 2005; 19: 466-486.
155. Zanarini MC, Frankenburg FR, Hennen J, Reich DB, Silk KR. Axis I comorbidity in patients with borderline personality disorder: 6-year follow-up and prediction of time to remission. *Am J Psychiatry* 2004; 161: 2108-2114.

156. Herman J. Complex PTSD: a syndrome in survivors of prolonged and repeated trauma. *J Trauma Stress* 1992; 5: 377-391.
157. Herman JL, Perry JC, van der Kolk BA. Childhood trauma in borderline personality disorder. *Am J Psychiatry* 1989; 146: 490-495.
158. Zanarini MC, Hörz S, Frankenburg FR, Weingeroff J, Reich DB, Fitzmaurice G. The 10-year course of PTSD in borderline patients and axis II comparison subjects. *Acta Psychiatrica Scand* 2011; 124: 349-356.
159. Cohen JA, Manninano AP. Psychotherapeutic options for traumatized children. *Curr Opin Pediatr* 2010; 22: 605-609.
160. Australian Centre for Posttraumatic Mental Health. Australian guidelines for the treatment of adults with acute stress disorder and posttraumatic stress disorder. Melbourne: ACPMH; 2007.
161. Australian Government. National standards for mental health services. Australian Government; 2010.
162. Beatson J, Rao S, Watson C. Borderline personality disorder: towards effective treatment. Fitzroy: Victorian Medical Post Graduate Foundation; 2010.
163. Grenyer BFS. Psychotherapy for borderline personality disorder: where to start; when to finish? (abstract). Conference paper presented at the XIIth International Society for the Study of Personality Disorders. *J Pers Disord* 2011; (Suppl): 9.
164. Westen D, Novotny CM, Thompson-Brenner H. The empirical status of empirically supported therapies: assumptions, findings, and reporting in controlled clinical trials. *Psychol Bull* 2004; 130: 631-633.
165. Gunderson JG. Borderline personality disorder: a clinical guide. Washington (DC): American Psychiatric Publishing, Inc; 2001.
166. Luborsky L, Diguer L, Seligman DA, Rosenthal R, Johnson S, Halperin G, Bishop M, Berman JS, Schweizer E. The researcher's own therapeutic allegiances: A 'wild card' in comparisons of treatment efficacy. *Clinical Psychology: Science and Practice* 1999; 6: 49-62.
167. Fischer M, Barkley RA, Smallish L, Fletcher K. Young adult follow-up of hyperactive children: self-reported psychiatric disorders, comorbidity, and the role of childhood conduct problems and teen CD. *J Abnorm Child Psychol* 2002; 30: 463-475.
168. Cohen P, Chen H, Gordon K, Johnson J, Brook J, Kasen S. Socioeconomic background and the developmental course of schizotypal and borderline personality disorder symptoms. *Dev Psychopathol* 2008; 20: 633-650.
169. Widom CS, Czaja SJ, Paris J. A prospective investigation of borderline personality disorder in abused and neglected children followed up into adulthood. *J Pers Disord* 2009; 23: 433-436.
170. Chanen AM, Kaess M. Developmental pathways to borderline personality disorder. *Curr Psychiatry Rep* 2011; 14: 45-53.

171. Bezirgianian S, Cohen P, Brook JS. The impact of mother-child interaction on the development of borderline personality disorder. *Am J Psychiatry* 1993; 150: 1836-1842.
172. Cohen P. Child development and personality disorder. *Psychiatr Clin North Am* 2008; 31: 477-493.
173. Carlson EA, Egeland B, Sroufe LA. A prospective investigation of the development of borderline personality symptoms. *Dev Psychopathol* 2009; 21: 1311-1334.
174. Rohde P, Lewinsohn PM, Kahler CW, Seeley JR, Brown RA. Natural course of alcohol use disorders from adolescence to young adulthood. *J Am Acad Child Adolesc Psychiatry* 2001; 40: 83-90.
175. Thatcher DL, Cornelius JR, Clark DB. Adolescent alcohol use disorders predict adult borderline personality. 2005; 30: 1709-1724.
176. Tomalski P, Johnson MH. The effects of early adversity on the adult and developing brain. *Curr Opin Psychiatry* 2010; 23: 233-238.
177. Roth TL, Sweatt JD. Annual Research Review: Epigenetic mechanisms and environmental shaping of the brain during sensitive periods of development. *J Child Psychol Psychiatry* 2011; 52: 398-408.
178. Gillespie CF, Phifer J, Bradley B, Ressler KJ. Risk and resilience: genetic and environmental influences on development of the stress response. *Depress Anxiety* 2009; 26: 984-992.
179. Green JG, McLaughlin KA, Berglund PA, Gruber MJ, Sampson NA, Zaslavsky AM, Kessler RC. Childhood adversities and adult psychiatric disorders in the national comorbidity survey replication I: associations with first onset of DSM-IV disorders. *Arch Gen Psychiatry* 2010; 67: 113-123.
180. Kasen S, Cohen P, Chen H, Johnson JG, Crawford TN. School climate and continuity of adolescent personality disorder symptoms. *J Child Psychol Psychiatry* 2009; 50: 1504-1512.
181. World Health Organization. International statistical classification of diseases and related health problems 10th Revision (Version 2007). Geneva: World Health Organization; 2007.
182. Project Air Team. Treatment guidelines for personality disorders Version 1.2 April 2011. NSW Health and Illawarra Health and Medical Research Institute; 2010.
183. Rao S. Diagnosing borderline personality disorder. In: Beatson J, Rao S, Watson C, editors. *Borderline personality disorder: towards effective treatment*. Fitzroy: Victorian Medical Post Graduate Foundation; 2010. p. 39-73.
184. Chanen AM, Jovev M, Jackson HJ. Adaptive functioning and psychiatric symptoms in adolescents with borderline personality disorder. *J Clin Psychiatry* 2007; 68: 297-306.
185. Chanen AM, Jovev M, McCutcheon L, Jackson HJ, McGorry PD. Borderline personality disorder in young people and the prospects for prevention and early intervention. *Curr Psychiatry Rev* 2008; 4: 48-57.

186. Miller AL, Muehlenkamp JJ, Jacobson CM. Fact or fiction: Diagnosing borderline personality disorder in adolescents. *Clin Psychol Rev* 2008; 28: 969-981.
187. Chanen AM, Jackson HJ, McGorry PD, Allott KA, Clarkson V, Yuen HP. Two-year stability of personality disorder in older adolescent outpatients. 2004; 18: 526-541.
188. Bernstein DP, Cohen P, Velez CN, Schwab-Stone M, Siever LJ, Shinsato L. Prevalence and stability of the DSM-III-R personality disorders in a community-based survey of adolescents. *Am J Psychiatry* 1993; 150: 1237-1243.
189. Chanen AM, McCutcheon LK, Germano D, Nistico H, Jackson HJ, McGorry PD. The HYPE Clinic: an early intervention service for borderline personality disorder. *J Psychiatr Pract* 2009; 15: 163-172.
190. Chanen AM, Jovev M, Djaja D, McDougall E, Yuen HP, Rawlings D, Jackson HJ. Screening for borderline personality disorder in outpatient youth. *J Pers Disord* 2008; 22: 353-364.
191. Poreh AM, Rawlings D, Claridge G, Freeman JL, Faulkner C, Shelton C. The BPQ: A scale for the assessment of borderline personality based on DSM-IV criteria. *J Pers Disord* 2006; 20: 247-260.
192. First MB, Gibbon M, Spitzer RL, Williams JBW. The Structured Clinical Interview for DSM-IV Axis II Personality Disorders (SCID-II). Washington, DC: American Psychiatric Press; 1997.
193. Zanarini MC, Vujanovic AA, Parachini EA, Boulanger JL, Frankenburg FR, Hennen J. A screening measure for BPD: the McLean Screening Instrument for Borderline Personality Disorder (MSI-BPD). *J Pers Disord* 2003; 17: 568-573.
194. Loranger AW, Sartorius N, Janca A. Assessment and Diagnosis of Personality Disorders: The International Personality Disorder Examination (IPDE). New York: Cambridge University Press; 1996.
195. Linehan MM, Tutek DA, Heard HL, Armstrong HE. Interpersonal outcome of cognitive behavioral treatment for chronically suicidal borderline patients. *Am J Psychiatry* 1994; 151: 1771-1776.
196. Kolla NJ, Links PS, McMain S, Streiner DL, Cardish R, Crook M. Demonstrating adherence to guidelines for the treatment of patients with borderline personality disorder. *Can J Psychiatry* 2009; 54: 181-189.
197. Gunderson JG, Links PS. Borderline personality disorder: a clinical guide. 2nd ed. Washington, DC: American Psychiatric Press; 2008.
198. Clarkin JF, Levy KN, Lenzenweger MF, Kernberg OF. Evaluating three treatments for borderline personality disorder: a multiwave study. *Am J Psychiatry* 2007; 164: 922-928.
199. Linehan MM. Cognitive-behavioural treatment of borderline personality disorder. New York: Guilford; 1993.
200. Korner A, Gerull F, Meares R, Stevenson J. Borderline personality disorder treated with the conversational model: a replication study. *Compr Psychiatry* 2006; 47: 406-411.

201. Stevenson J, Meares R. An outcome study of psychotherapy for patients with borderline personality disorder. *Am J Psychiatry* 1992; 149: 358-362.
202. Stevenson J, Meares R, D'Angelo R. Five-year outcome of outpatient psychotherapy with borderline patients. *Psychol Med* 2005; 35: 79-87.
203. Rockland LH. Supportive therapy for borderline patients: a psychodynamic approach. New York: The Guilford Press 1992.
204. Dolan BM, Evans C, Wilson J. Therapeutic community treatment for personality disordered adults: changes in neurotic symptomatology on follow-up. *Int J Soc Psychiatry* 1992; 38: 243-250.
205. Weinberg I, Ronningstam E, Goldblatt MJ, Schechter M, Maltzberger JT. Common factors in empirically supported treatments of borderline personality disorder. *Curr Psychiatry Rep* 2011; 13: 60-68.
206. Shapiro DA, Firth-Cozens J, Stiles WB. The question of therapists' differential effectiveness. A Sheffield Psychotherapy Project addendum. *Br J Psychiatry* 1989; 154: 383-385.
207. Reich DB, Zanarini MC, Bieri KA. A preliminary study of lamotrigine in the treatment of affective instability in borderline personality disorder. *Int Clin Psychopharmacol* 2009; 24: 270-275.
208. Cornelius JR, Soloff PH, Perel JM, Ulrich RF. Continuation pharmacotherapy of borderline personality disorder with haloperidol and phenelzine. *Am J Psychiatry* 1993; 150: 1843-1848.
209. Cornelius JR, Soloff PH, George A, Ulrich RF, Perel JM. Haloperidol vs. phenelzine in continuation therapy of borderline disorder. *Psychopharmacol Bull* 1993; 29: 333-337.
210. Makela EH, Moeller KE, Fullen JE, Gunel E. Medication utilization patterns and methods of suicidality in borderline personality disorder. *Ann Pharmacother* 2006; 40: 49-52.
211. Zanarini MC, Frankenburg FR. A preliminary, randomized trial of psychoeducation for women with borderline personality disorder. *J Pers Disord* 2004; 22: 284-290.
212. Tyrer P, Tom B, Byford S, Schmidt U, Jones V, Davidson K, Knapp M, Macloed A, Catalan J, POPMACT Group. Differential effects of manual assisted cognitive behavior therapy in the treatment of recurrent deliberate self-harm and personality disturbance: the POPMACT study. *J Pers Disord* 2004; 18: 102-116.
213. Chanen AM. Unpublished report [Cited in National Collaborating Centre for Mental Health. Borderline personality disorder: treatment and management. National clinical practice guideline number 78. Leicester: The British Psychological Society and The Royal College of Psychiatrists; 2009].
214. Linehan MM, Schmidt H, Dimeff LA, Craft JC, Kanter J, Comtois KA. Dialectical behavior therapy for patients with borderline personality disorder and drug-dependence. *Am J Addict* 1999; 8: 279-292.
215. Waltz J, Dimeff LA, Koerner K, Linehan MM, Taylor L, Miller C. Feasibility of using video to teach a dialectical behavior therapy skill to clients with borderline personality disorder *Cogn Behav Pract* 2009; 16: 214-222.

216. Gregory RJ, Remen AL. A manual-based psychodynamic therapy for treatment-resistant borderline personality disorder. *Psychotherapy: Theory/Research/Practice/Training* 2008; 45: 15-27.
217. Jackson HJ, Burgess PM. Personality disorders in the community: results from the Australian National Survey of Mental Health and Well-being Part III. Relationships between specific type of personality disorder, Axis 1 mental disorders and physical conditions with disability and health consultations. *Soc Psychiatry Psychiatr Epidemiol* 2004; 39: 765-776.
218. Slotema CW, Daalman K, Blom JD, Diederken KM, Hoek HW, Sommer IE. Auditory verbal hallucinations in patients with borderline personality disorder are similar to those in schizophrenia. *Psychol Med* 2012; 16 Feb Epub ahead of print: 1-6.
219. Kingdon DG, Ashcroft K, Bhandari B, Gleeson S, Warikoo N, Symons M, Taylor L, Lucas E, Mahendra R, Ghosh S, Mason A, Badrakalimuthu R, Hepworth C, Read J, Mehta R. Schizophrenia and borderline personality disorder: similarities and differences in the experience of auditory hallucinations, paranoia, and childhood trauma. *J Nerv Ment Dis* 2010; 198: 399-403.
220. Barnow S, Arens EA, Sieswerda S, Dinu-Biringer R, Spitzer C, Lang S. Borderline personality disorder and psychosis: a review. *Curr Psychiatry Rep* 2010; 12: 186-195.
221. Philipsen A. Differential diagnosis and comorbidity of attention-deficit/hyperactivity disorder (ADHD) and borderline personality disorder (BPD) in adults. *Eur Arch Psychiatry Clin Neurosci* 2006; 256(Suppl 1): i42-i46.
222. Distel MA, Carlier A, Middeldorp CM, Derom CA, Lubke GH, Boomsma DI. Borderline personality traits and adult attention-deficit hyperactivity disorder symptoms: a genetic analysis of comorbidity. *Am J Med Genet B Neuropsychiatr Genet* 2011; 156B: 817-825.
223. Chen EY, Brown MZ, Lo TT, Linehan MM. Sexually transmitted disease rates and high-risk sexual behaviors in borderline personality disorder versus borderline personality disorder with substance use disorder. *J Nerv Ment Dis* 2007; 195: 125-129.
224. Arntz A, van den Hoorn M, Cornelius J, Verheul R, van den Bosch WM, de Bie AJ. Reliability and validity of the borderline personality disorder severity index. *J Pers Disord* 2003; 17: 45-59.
225. Zanarini MC, Vujanovic AA, Parachini EA, Boulanger JL, Frankenburg FR, Hennen J. Zanarini Rating Scale for Borderline Personality Disorder (ZAN-BPD): a continuous measure of DSM-IV borderline psychopathology. *J Pers Disord* 2003; 17: 233-242.
226. Beyond local services: commissioning and providing services for people with complex and severe personality disorders: UK Department of Health; [cited August 2012]. Available from: UK National Personality Disorder Website <http://www.pdprogramme.org.uk/assets/resources/167.pdf>.
227. Palmer S, Davidson K, Tyrer P, Gumley A, Tata P, Norrie J, Murray H, Seivewright H. The cost-effectiveness of cognitive behavior therapy for borderline personality disorder: results from the BOScot trial. *J Pers Disord* 2006; 20: 466-481.

228. van Asselt AD, Dirksen CD, Arntz A, Giesen-Bloo JH, van Dyck R, Spinhoven P, van Tilburg W, Kremers IP, Nadort M, Severens JL. Out-patient psychotherapy for borderline personality disorder: cost-effectiveness of schema-focused therapy v. transference-focused psychotherapy. *Br J Psychiatry* 2008; 192: 450-457.
229. Hall J, Caleo S, Stevenson J, Meares R. An economic analysis of psychotherapy for borderline patients. *J Ment Health Policy Econ* 2001; 4: 3-8.
230. Bateman A, Fonagy P. Health service utilization costs for borderline personality disorder patients treated with psychoanalytically oriented partial hospitalization versus general psychiatric care. *Am J Psychiatry* 2003; 160: 169-171.
231. Brazier J, Tumur I, Holmes M, Ferriter M, Parry G, Dent-Borwn K, Paisley S. Psychological therapies including dialectical behaviour therapy for borderline personality disorder: a systematic review and preliminary economic evaluation. *Health Technol Assess* 2006; 10: iii, ix-xii, 1-117.
232. Dolan BM, Warren FM, Menzies D, Norton K. Cost-offset following specialist treatment of severe personality disorders. *Psychiatric Bulletin* 1996; 40: 413-417.
233. Beecham J, Slead M, Knapp M, Chiesa M, Drahorad C. The costs and effectiveness of two psychosocial treatment programmes for personality disorder: a controlled study. *Eur Psychiatry* 2006; 21: 102-109.
234. Pasieczny N, Connor J. The effectiveness of dialectical behaviour therapy in routine public mental health settings: an Australian controlled trial. *Behav Res Ther* 2011; 49: 4-10.
235. Bartak A, Andrea H, Spreeuwenberg MD, Ziegler UM, Dekker J, Rossum BV, Hamers EF, Scholte W, Aerts J, Busschbach JJ, Verheul R, Stijnen T, Emmelkamp PM. Effectiveness of outpatient, day hospital, and inpatient psychotherapeutic treatment for patients with cluster B personality disorders. *Psychother Psychosom* 2011; 80: 28-38.
236. Watson C, Rao S, Beatson J. Management of borderline personality disorder in public mental health settings. In: Beatson J, Rao S, Watson C, editors. *Borderline personality disorder: towards effective treatment*. Fitzroy: Victorian Medical Post Graduate Foundation; 2010. p. 269-292.
237. Bower P, Gilbody S. Stepped care in psychological therapies: access, effectiveness and efficiency: narrative literature review. *Br J Psychiatry* 2005; 186: 1-11.
238. Beatson J, Rao S. Psychotherapy for borderline personality disorder. In: Beatson J, Rao S, Watson C, editors. *Borderline personality disorder: towards effective treatment*. Fitzroy: Victorian Medical Post Graduate Foundation; 2010. p. 125-166.
239. Dimeff LA, Woodcock EA, Harned MS, Beadnell B. Can dialectical behavior therapy be learned in highly structured learning environments? Results from a randomized controlled dissemination trial. *Behav Ther* 2011; 42: 263-275.
240. Commons Treloar AJ. Effectiveness of education programs in changing clinicians' attitudes toward treating borderline personality disorder. *Psychiatr Serv* 2009; 60: 1128-1131.

241. Beatson J, Watson C. Team psychodynamics and leadership. In: Beatson J, Rao S, Watson C, editors. *Borderline personality disorder: towards effective treatment*. Fitzroy: Victorian Medical Post Graduate Foundation; 2010. p. 213-236.
242. Gunderson JG, Daversa MT, Grilo CM, McGlashan TH, Zanarini MC, Shea MT, Skodol AE, Yen S, Sanislow CA, Bender DS, Dyck IR, Morey LC, Stout RL. Predictors of 2-year outcome for patients with borderline personality disorder. *Am J Psychiatry* 2006; 163: 822-826.
243. Hooley JM, Hoffman PD. Expressed emotion and clinical outcome in borderline personality disorder. *Am J Psychiatry* 1999; 156: 1557-1562.
244. Hoffman PD, Buteau E, Hooley JM, Fruzzetti AE, Bruce ML. Family members' knowledge about borderline personality disorder: correspondence with their levels of depression, burden, distress, and expressed emotion. *Fam Process* 2003; 42: 469-478.
245. The Royal Australian and New Zealand College of Psychiatrists. *Self-harm. Australian treatment guide for consumers and carers*. Melbourne: The Royal Australian and New Zealand College of Psychiatrists; 2009.
246. Hoffman PD, Buteau E, Fruzzetti AE. Borderline personality disorder: NEO-Personality Inventory ratings of patients and their family members. *Int J Soc Psychiatry* 2007; 53: 204-215.
247. Hoffman PD, Fruzzetti AE, Buteau E, Neiditch ER, Penney D, Bruce ML, Hellman F, Struening. Family connections: a program for relatives of persons with borderline personality disorder. *Fam Process* 2005; 44: 217-225.
248. Scheirs JG, Bok S. Psychological distress in caretakers or relatives of patients with borderline personality disorder. *Int J Soc Psychiatry* 2007; 53: 195-203.
249. Mental Health Council of Australia. *Adversity to advocacy: the lives and hopes of mental health carers*. MHCA; 2009.
250. Mental Health Council of Australia. *Mental health carers report (Mental Health Carers Survey 2010)*. MHCA; 2010.
251. Cowling V, Garrett M. Children of parents with mental illness and their family relationships. COPMI Gateway to Evidence that Matters (GEMS) [serial on the Internet]. 2009 [cited August 2012]; Edition 3: Available from: http://www.copmi.net.au/gems/files/copmi_gems_3_dec_08.pdf.
252. Australian Infant Child Adolescent and Family Mental Health Association. *Principles and actions for services and people working with children of parents with a mental illness*. Stepney: Australian Infant, Child, Adolescent and Family Mental Health Association; 2004.
253. Mercer N, Lees R. Ulysses agreements in supporting families affected by parental mental illness. COPMI Gateway to Evidence that Matters (GEMS) [serial on the Internet]. 2010 [cited August 2012]; Edition 8: Available from: http://www.copmi.net.au/gems/files/COPMI_gems_08_001.pdf.
254. Sivec H, Masterson P. When a parent is hospitalised: the impact on children. COPMI Gateway to Evidence that Matters (GEMS) [serial on the Internet]. 2009 [cited August 2012]; Edition 5: Available from: http://www.copmi.net.au/gems/files/Copmigems05_002.pdf.

255. Cowling V, Thornton K. Pre-school children in families with mental illness. COPMI Gateway to Evidence that Matters (GEMS) [serial on the Internet]. 2009 [cited August 2012]; Edition 7: Available from: http://www.copmi.net.au/gems/files/COPMI_Gems_07_001.pdf.
256. Newman LK, Stevenson CS, Bergman LR, Boyce P. Borderline personality disorder, mother/infant interaction and parenting perceptions: preliminary findings. *Aust N Z J Psychiatry* 2007; 41: 598-605.
257. Newman L, Stevenson C. Parenting and borderline personality disorder: ghosts in the nursery. *Clin Child Psychol Psychiatry* 2005; 10: 385-394.
258. Maybery D, Korhonen T. Issues for mental health workers when working with children and parents. COPMI Gateway to Evidence that Matters (GEMS) [serial on the Internet]. 2009 [cited August 2012]; Edition 6: Available from: http://www.copmi.net.au/gems/files/COPMI_Gems_07_001.pdf.
259. Hoffman PD, Fruzzetti AE, Buteau E. Understanding and engaging families: An education, skills and support programme for relatives impacted by borderline personality disorder. *J Ment Health* 2007; 16: 69-82.
260. Dixon L, McFarlane WR, Lefley H, Lucksted A, Cohen M, Falloon I, Mueser K, Solomon P, Sonheimer D. Evidence-based practices for services to families of people with psychiatric disabilities. *Psychiatr Serv* 2001; 52: 903-910.
261. Thornton K. Keeping the infant in mind in the presence of maternal mental illness. COPMI Gateway to Evidence that Matters (GEMS) [serial on the Internet]. 2010 [cited August 2012]; Edition 10: Available from: http://www.copmi.net.au/gems/files/GEMS_10_final.pdf.
262. Newman L, Stevenson C. Issues in infant-parent psychotherapy for mothers with borderline personality disorder. *Clin Child Psychol Psychiatry* 2008; 13: 505-514.
263. Bourke ME, Grenyer BF. Psychotherapists' response to borderline personality disorder: a core conflictual relationship theme analysis. *Psychother Res* 2010; 20: 680-691.
264. Paris J. Half in love with death – managing the chronically suicidal patient. New Jersey: Lawrence Erlbaum Associates, Inc; 2007.
265. Zanarini MC, Frankenburg FR, Ridolfi ME, Jager-Hyman S, Hennen J, Gunderson JG. Reported childhood onset of self-mutilation among borderline patients. *J Pers Disord* 2006; 20: 9-15.
266. Beatson J. Self-harm and suicidality in borderline personality disorder. In: Beatson J, Rao S, Watson C, editors. *Borderline personality disorder: towards effective treatment*. Fitzroy: Victorian Medical Post Graduate Foundation; 2010. p. 167-191.
267. Kolla NJ, Eisenberg H, Links PS. Epidemiology, risk factors, and psychopharmacological management of suicidal behavior in borderline personality disorder. *Arch Suicide Res* 2008; 12: 1-19.
268. Links PS, Kolla NJ. Assessing and managing suicide risk. In: Oldham JM, Skodol AE, Bender DS, editors. *The American Psychiatric Publishing textbook of personality disorders*. Washington, D.C: American Psychiatric Publishing, Inc; 2005.

269. Kullgren G. Factors associated with completed suicide in borderline personality disorder. *J Nerv Ment Dis* 1988; 176: 40-44.
270. Kullgren G, Renberg E, Jacobson L. Borderline personality disorder and psychiatric suicides. An analysis of 11 consecutive cases. *Nord J Psychiatry* 1985; 39: 328-331.
271. Kjelsberg E, Eikeseth PH, Dahl AA. Suicide in borderline patients – predictive factors. *Acta Psychiatr Scand* 1991; 84: 283-287.
272. Isometsä ET, Henriksson MM, Heikkinen ME, Aro HM, Marttunen MJ, Kuoppasalmi KI, Lönngvist JK. Suicide among subjects with personality disorders. *Am J Psychiatry* 1996; 153: 667-673.
273. McGirr A, Paris J, Lesage A, Renaud J, Turecki G. Risk factors for suicide completion in borderline personality disorder: a case-control study of cluster B comorbidity and impulsive aggression. *J Clin Psychiatry* 2007; 68: 721-729.
274. Runeson B, Beskow J. Borderline personality disorder in young Swedish suicides. *J Ment Nerv Dis* 1991; 179: 153-156.
275. Heikkinen ME, Isometsä ET, Henriksson MM, Marttunen MJ, Aro HM, Lönngvist JK. Psychosocial factors and completed suicide in personality disorders. *Acta Psychiatr Scand* 1997; 95: 49-57.
276. Heikkinen ME, Henriksson MM, Isometsä ET, Marttunen MJ, Aro HM, Lönngvist JK. Recent life events and suicide in personality disorders. *J Nerv Ment Dis* 1997; 185: 373-381.
277. Paris J. Chronic suicidality among patients with borderline personality disorder. *Psychiatr Serv* 2002; 53: 738-742.
278. Paris J. Is hospitalization useful for suicidal patients with borderline personality disorder? *J Pers Disord* 2004; 18: 240-247.

Notes

Notes



www.nhmrc.gov.au

GPO Box 1421, Canberra ACT 2601

16 Marcus Clarke Street, Canberra City ACT

T. 13 000 NHMRC (13 000 64672) or +61 2 6217 9000 F. 61 2 6217 9100 E. nhmrc@nhmrc.gov.au