Review Article

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A review of NICE guidelines on the management of Borderline Personality Disorder

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Abstract

Aims and objectives: This report aims to review the current guidelines regarding the management of Borderline Personality Disorder and explore the literature according to the research recommendations. The psychological/psychosocial and pharmacological aspects will be the focus of this review.

Methods: A summary of the NICE guidance was made and each recommended psychotherapy (i.e. mentalization-based therapy, dialectical behaviour therapy, cognitive analytic therapy, cognitive behavioural therapy, schema-focused therapy and transference focussed therapy) and pharmacological options were dissected and analysed using the literature.

Results: All of the psychotherapies showed promising results when applied to borderline personality disorder. Two were seen as superior due to there being more evidence to support their use. In terms of psychotropics, despite the NICE guidance negating their use, the literature found evidence that some second-generation antipsychotics and mood stabilisers could improve symptoms in the short term. Those pharmacological agents that carry the strongest evidence base should be considered if off-label use is deemed appropriate.

Conclusion: Specialist psychological treatments such as dialectical behaviour therapy and mentalization based therapy substantiate the use of psychotherapy in borderline personality disorder. By crystallising the important aspects of the array of psychotherapies available, a more comprehensive approach could be developed. By understanding the disorder in terms of psychological and biological aberrations, it will enable a more specific dual approach to its management in the future.

Keywords: Borderline Personality Disorder, Emotionally unstable personality disorder, Personality disorder.

Abbreviations: BPD - Borderline Personality Disorder, DSM-5 - The Diagnostic and Statistical Manual of Mental Disorder, ICD-10 - The International Classification of Diseases, NICE - The National Institute for Health and Care Excellence, DBT - Dialectical Behaviour Therapy, MBT - Mentalization Based Treatment, CAT - Cognitive Analytic Therapy, NHS - National Health Service (UK), CBT - Cognitive behavioural therapy, TFT - Transference focussed therapy, NHMRC – The National Health and Medical Research Council of Australia.

INTRODUCTION

During my placement in Psychiatry at the Brooker Centre, Runcorn, UK, I have come into contact with a wide array of psychiatric disorders, none more so than borderline personality disorder (BPD). It is undoubtedly one of the most prevalent problems in the area which the Brooker Centre serves. I can recall an example of a patient with BPD who had been quite unwell for a prolonged period of time and had struggled with affective instability. This patient had been quite successfully treated with Lithium therapy, has exhibited stability and is happy on the current treatment. There is a pattern of pharmacological treatment in BPD patients despite the fact that guidelines suggest otherwise…

Personality disorders are defined as 'an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adulthood, is stable over time, and leads to distress or impairment' . Personality disorders are representative of long-term functioning and are not considered in terms of episodes of illness [1].

The Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5), groups the various personality disorders into three clusters based on their descriptive similarities.

Cluster A includes the Paranoid, Schizoid, and Schizotypal personality disorders which are categorised as 'odd/eccentric';

Cluster B includes the Antisocial, Borderline, Histrionic, and Narcissistic personality disorders which are categorised as 'dramatic/emotional/erratic';

*Cluster C*includes the Avoidant, Dependent, and Obsessive-compulsive personality disorders which are categorised as 'anxious/fearful' [2].

The International Classification of Diseases, 10th edition (ICD-10), specifies the condition of emotionally unstable personality disorder which has two subtypes: The impulsive type and the borderline type. The borderline type in essence overlaps with the DSM-5 definition [3].

It has proven difficult to provide robust clinical recommendations with regards to the treatment of personality disorder. This is, in part, due to the fact that study populations are diverse but also compounded by the use of different assessment criteria. Furthermore, it is important to consider that personality disorders often present with a great deal of psychiatric comorbidity. Of the personality disorders, particular attention has been paid to borderline personality disorder (BPD) as the symptom clusters which it involves have been shown to improve considerably with treatment [4].

Figure 1: Diagnostic Criteria for Borderline Personality Disorder according to DSM-5 [2]:

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:
1. Frantic efforts to avoid real or imagined abandonment. (Note: Do not include suicidal or self-mutilating behaviour covered in Criterion 5.)
2. A pattern of unstable and intense interpersonal relationships characterised by alternating between extremes of idealization 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). (Note: Do not include suicidal or self-mutilating behaviour covered in Criterion 5.)
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.

Borderline personality disorder is characterised by a pervasive instability in mood, interpersonal relationships, self-image and behaviour. The condition was first recognised in the United States by Adolf Stern in 1938. He described that these are a group of patients who neither fit into psychotic or psychoneurotic group, which gave rise to the term 'borderline'. BPD is often diagnostically comorbid with depression and anxiety, eating disorders (notably bulimia), post-traumatic stress disorder, substance misuse and bipolar affective disorder. Furthermore, psychotic disorders have also been found to overlap. Due to this extent of comorbidity it is rare to see a patient who has a pure BPD [5].

The pharmacological treatments of BPD are tailored according to the symptom clusters that present. These include impulsivity, affective instability, transient stress-related psychotic symptoms and suicidal & self-injurious behaviours [5,6].

Recommended Psychological and Pharmacological treatment, 2009 National Institute for Health and Clinical Excellence (NICE) guidelines on Borderline Personality Disorder [5, 7]:

Psychological

NICE guidelines state that when offering psychology for BPD or for the individual symptoms of the disorder, brief psychological interventions (i.e. less than a 3 month period) should not be used. It states that the frequency of psychotherapy sessions should be adapted to the patient's needs and 'context of living' and suggests that twice-weekly session may be considered. The guidelines also specify that for women with BPD for whom recurrent self-harm is a priority, a comprehensive dialectical behaviour therapy programme should be considered. NICE recommends that when psychological treatment is provided in BPD, the effects should be monitored using a broad range of outcomes. These should include personal functioning, drug and alcohol use, self-harm, depression and the symptoms of BPD.

Pharmacological

The NICE guidance states that drug treatment should not be used specifically for BPD or for the individual symptoms or behaviour associated with the disorder (e.g. repeated self-harm, marked emotional instability, risk taking behaviour and transient psychotic symptoms). It goes on to suggest that antipsychotics should not be used for the medium- and long term treatment of BPD. However, with regards to the management of comorbidities, it specifies that drug treatment may be considered and that in each case, the NICE guidelines for each comorbid condition must be referred to. Antidepressants, mood stabilisers and antipsychotics are commonly used in clinical practice. The guidelines mention that short-term use of sedative medication may be considered in a crisis. 'Short-term' denotes treatment lasting no longer than one week.

With regards to drug treatment during a period of crisis, NICE recommends that there should be a consensus among prescribers and other involved professionals about the proposed drug treatment and also that a primary prescriber should be identified. There should be an appreciation of the likely risks of prescribing, including alcohol and illicit drug use. NICE emphasises that the psychological role of prescribing (both from the patient's and prescriber's perspective) should be taken into account, and the impact that such prescribing decisions may have on the therapeutic relationship and overall care plan. NICE recommends that a single drug be used and that polypharmacy is to be avoided as much as possible.

In a crisis NICE recommends prescribing 'a drug that has a low side-effect profile, low addictive properties, minimum potential

for misuse and relative safety in overdose.' The minimum effective dose is favourable, prescribing fewer tablets more frequently if there is a significant risk of overdose and also agreeing with patient on the symptoms that are being targeted. NICE suggests that following a crisis, a plan should be made to stop drug treatment that was started during a crisis. If this is not possible, a regular review of the effectiveness, side effects, misuse and dependency of the drug is advised. BPD patients can often have concomitant insomnia and for this, NICE details basic advice regarding sleep hygiene and forwards on to the guidance on the use of zaleplon, zolpidem and zopiclone for the short-term pharmacological management of insomnia.

AIMS AND OBJECTIVES

This report will review the current guidelines specifically regarding the management of borderline personality disorder and explore the literature according to the research recommendations that are set by NICE. The report is to focus on the two aspects of the management of BPD – The psychological/psychosocial aspect and the pharmacological aspect.

CURRENT NICE GUIDELINES ON PSYCHOLOGICAL AND PHARMACOLOGICAL TREATMENT OF BPD [7]:

Psychology

Mentalisation-based therapy and *dialectical behavioural therapy* are proposed in the setting of a 'well structured, high quality community based service' e.g. a day hospital setting or a community mental health team. NICE suggests that these techniques should be compared with 'high-quality community care delivered by general mental health service without the psychological intervention for people with BPD' in order to measure efficacy. For outpatients, *cognitive analytic therapy*,*cognitive behavioural therapy*, *schema-focussed therapy* and *transference focussed therapy* are suggested and are catered to those with less severe BPD (i.e. fewer comorbidities, higher level of social functioning, greater ability to depend on self-management methods). Randomised controlled trials reporting medium term outcomes (e.g. quality of life, psychosocial functioning, employment outcomes and BPD symptomatology) of a minimum of 18 months are recommended

Pharmacology

Mood stabilisers are proposed as it is detailed that emotional instability is a key feature in BPD. In particular, topiramate and lamotrigine are mentioned as they have been shown to produce encouraging results in small-scale studies. A randomised placebo-controlled trial with medium to long-term follow up is recommended.

ANALYSIS

Psychology: Dialectical Behaviour Therapy (DBT)

Dialectics can be defined as the art of investigating the relative truth of opinions, principles, and guidelines [8]. Dialectical in DBT refers to a means of arriving at the truth by examination of the argument i.e. the 'thesis' and 'antithesis' and resolving the two into a rational synthesis. DBT was introduced in 1991 by Marsha Linehan (a psychology researcher) and colleagues tailored as a treatment for BPD. In this, patients are supported in understanding their own emotional experiences and are taught new skills for dealing with their stresses. A combination of individual and group sessions are used. More adaptive responses and effective problem-solving techniques are integrated to improve functioning and quality of life as well as improving morbidity and mortality [9, 10].

A study published in 2015 by M. Linehan et al detailed a randomized clinical trial that set out to compare

1) Standard DBT (DBT group skills training + DBT individual therapy) with

2) A treatment that evaluated DBT group skills training with manual case management (i.e. with the removal of DBT individual therapy) and

3) A treatment that removed DBT skills training by providing only DBT individual therapy with an activities group and prohibited individual therapists from teaching DBT skills.

All 3 versions of the treatment were found to be comparably effective at reducing suicide attempts, suicidal ideation, medical severity of intentional self-harm, use of crisis services owing to suicidality and improving reasons for living [11].

Psychology: Mentalization based therapy

Mentalization is 'the process by which we make sense of each other and ourselves, implicitly and explicitly, in terms of subjective states and mental processes.' It is a social construct suggesting that we are attentive to the mental states of those we are with, physically or psychologically [12]. Mentalization based treatment is a psychosocial treatment for BPD in which therapists monitor attachment and mentalizing capacity, and use interventions that aim to reinstate or maintain the capacity of patients to mentalize [13].

A longitudinal study, published in 2008, involving an eight-year follow-up of patients treated for BPD evaluated the effect of mentalization-based treatment (MBT) with partial hospitalization compared with treatment as usual. Five years after discharge from MBT, the MBT group exhibited clinical and statistical superiority to treatment as usual measured on suicidality, diagnostic status, service use, medication use, global function and vocational status [14]. A more recent review article, published in 2015, emphasises the consideration of disruptions in three closely related domains in individuals with BPD. These are 'in attachment relationships, in different polarities of mentalizing, and in the quality of epistemic vigilance and trust'. It is suggested that this approach allows seemingly paradoxical features of BPD patients appear more coherent. It is supposed that this approach provides a clear focus for the therapist enabling them to monitor the therapeutic process in terms of

imminent mentalizing impairments and epistemic mistrust due to activation of the attachment system.

The article goes on to assert that the effectiveness of MBT in BPD may be elucidated due to the fact that it 'enables the therapist to maintain and foster a mentalizing stance, even–and perhaps particularly–under high arousal conditions that are so characteristic of work with these patients' [15].

***Psychology*: Cognitive analytic therapy (CAT)**

CAT is a brief focal therapy that is informed by cognitive therapy, psychodynamic psychotherapy and elements of cognitive psychology. It was originally developed by Anthony Ryle tailored towards the needs of the NHS [16]. It is based on a collaborative therapeutic position which sets out to create narrative and diagrammatic reformulations with patients concerning their difficulties. The theory centres on descriptions of sequences of linked external, mental and behavioural events. At first, the emphasis was on how such procedural sequences prevented revision of dysfunctional ways of living. More recently, this has been extended to understanding the origins of reciprocal role procedures in early life and their repetition in current relationships and self-management [17].

One study detailed a randomised controlled trial which aimed to investigate the effectiveness of time-limited CAT for participants with personality disorder. The study found that participants receiving CAT exhibited reduced symptoms and showed considerable improvement compared with the control group who showed signs of deterioration during the treatment period. They concluded that CAT is superior to treatment as usual in improving outcomes associated with personality disorder [18].

***Psychology*: Cognitive behavioural therapy (CBT) and Schema-focussed therapy**

CBT is a time-limited, problem focussed psychotherapy that has been applied to a wide range of psychiatric disorders. The development of this technique was born out of the observation that patients referred for psychotherapy often would hold ingrained, negatively skewed assumptions of themselves, their future and their environment. The therapy is based on the notion that disorder is caused not by life events, but by the view the patient adopts of events. The therapy focusses on current problems and helps to develop new skills to provide symptom relief and sustain recovery [9, 19].

Initially CBT was predominantly insight-orientated, using introspection to bring about change. Beck et al began to integrate a range of behavioural techniques to improve the impact on dysfunctional controlling belief systems (schemas). The goal of treatment is not to replace the dysfunctional schemas; it aims to modify beliefs and develop new ones allowing the patient to cope more effectively in challenging situations [20, 21].

A 2013 review article that set to explore schema-focussed therapy concluded that schema-therapy is based on a 'cohesive theoretical model' and that there seems to be sufficient evidence supporting its validity. Regarding effectiveness, it goes on to indicate that one should be encouraged by the results of studies, however it points out that due to the small number of 'methodologically-good efficacy studies' it is difficult to be certain. The article claims that when evaluated against other psychotherapeutic treatments, specifically DBT and MBT, schema-therapy requires more investigation [22]. A pilot study (2013) set out to monitor the effects of group schema-based CBT on global symptomatic distress in young adults with personality disorders or features of personality disorder. Their findings provide preliminary evidence that schema-based CBT might be an effective treatment [23].

Furthermore, there is a multicentre randomized controlled trial being conducted with the aim of investigating schema-focussed therapy versus treatment as usual in BPD, which has a closing date of 1st February 2016 [24].

***Psychology*: Transference focussed therapy (TFT)**

The classic use of the term transference originates in psychoanalysis and comprises "the redirection of feelings and desires and especially of those unconsciously retained from childhood toward a new object" [25]. Transference-focussed psychotherapy is an evidence-based manualised treatment using a psychodynamic approach with a focus on object relations theory [26]. TFT aims to 'facilitate the reactivation, under controlled circumstances, of the dissociated internalised object relations in the transference relationship to observe the nature of the patient's split polarised internal representations, and then, through a multistep interpretive process, work to integrate them into a fuller, richer, and more nuanced identity [27].

Yeomans et al produced an article in 2013 consisting of vignettes to illustrate the techniques used in TFT with the view to evaluate its use in treating BPD. Their findings supported the validity of TFT in treating BPD patients who specifically had difficulty with relationships.

They distilled TFT down to three important components [28]:

1) The treatment contracting/setting the frame

2) Managing one's affective response

3) The interpretative process

Pharmacology

A Cochrane intervention review assessing the effects of drug treatments in BPD, included twenty-eight randomised control trials, published in the period 1979-2009 (20 of 28 trials dating from 2000 or later), involving a total of 1742 participants [29].

The authors arrived at the conclusion that pharmacotherapy in BPD 'is not based on good evidence from trials'. The review found that there is support for the use of Second-generation antipsychotics (in improving cognitive-perceptual symptoms

and affective dysregulation); Mood stabilisers (in diminishing affective-dysregulation and impulsive-aggressive symptoms); and Omega-3 fatty acids.

Figure 2: The pharmacological agents that were tested included the following:

First-generation antipsychotics:
Flupenthixol decanoate
Haloperidol
Thiothixene
Second-generation antipsychotics:
Aripriprazole
Olanzapine
Ziprasidone
Mood stabilisers:
Carbamazepine
Valproate semisodium
Lamotrigine
Topiramate
Antidepressants:
Amitriptyline
Fluoxetine
Fluvoxamine
Phenelzine sulfate
Mianserin
Dietary supplementation:
Omega-3 fatty acid

However, these claims were made based on single study effects and therefore require replication. No drug was found to significantly affect the symptom clusters, specific to BPD, including avoidance of abandonment, chronic feelings of emptiness, identity disturbance, and dissociation.

One noteworthy finding was that Olanzapine was associated with an increase in self-harming behaviour. Furthermore, the review states that 'special attention' is needed in BPD when prescribing tricyclic antidepressants (due to toxic effects in overdose) and hypnotics & sedatives (due to there being potential for misuse or dependence). Another problem that was highlighted was that in comorbid eating disorders the use of Olanzapine can contribute to weight gain and Topiramate can produce weight loss.

The review goes on to elucidate that there is not any evidence from randomised controlled trials that any drug reduces the severity of BPD and that it consists of 'distinct pathology facets'. They recommend that the pharmacotherapy of BPD should be targeted at 'defined symptoms' and that polypharmacy is not supported by the latest evidence and should be avoided as much as possible.

The authors end by reaffirming that the evidence is not robust and that the studies may not satisfactorily reflect certain characteristics of the clinical environment. They propose that further research is needed in order to produce reliable recommendations. They detail the complications that arise from the 'polythetic nature' of BPD i.e. each patient is likely to experience different aspects of the disorder. There lacks a consensus among researchers about a common battery of outcome variables and measures. They comment that there is a fragmentary view on drug effects and that it is unknown as to how the alteration of one symptom affects another.

Comorbidity

Comorbidity is a foremost concern in the interpretation of data concerning personality disorders [30]. A majority of individuals diagnosed with one personality disorder often meet criteria for at least one other personality disorder [30]. A large proportion of patients with personality disorder have one axis I [31] disorder comorbidly, mostly depression, anxiety and alcohol and substance use disorders [32]. [Axis I is a reference to the multi-axial classification system used in the Diagnostic and Statistical Manual of Mental Disorders that was removed in the latest version, DSM-5 [2]

It is important to consider therefore that, an improvement in the symptom clusters in personality disorders might be an improvement in comorbid axis I disorder symptoms. It is reported that the rates of depression are very high in BPD [33] and that the response to antidepressants in depressed individuals with comorbid personality disorders appears lower than in those without comorbid personality disorder [32].

The most recent guidance on the treatment of BPD from the National Health and Medical Research Council of Australia (NHMRC), which reviewed the literature and integrated a series of meta-analyses, details that pharmacotherapy does appear to be effective in altering the nature and course of BPD and that evidence does not warrant the use of pharmacotherapy as a sole or first-line treatment for BPD [34].

DISCUSSION

All of the aforementioned psychotherapy techniques are shown to produce promising results when applied to the treatment of BPD, with some standing out, such as DBT and MBT, due to the presence of a relatively robust evidence base. With such a wide variety of different approaches that all show some propensity for successful treatment of BPD it is clear that these approaches must be taken more seriously in clinical practice. These treatments have been shown to considerably improve symptomatic outcomes however there is a shortcoming in that they have failed to significantly improve social functioning. Each of the therapies follow distinct theories, however, when each treatment modality is applied to BPD, similar effects are seen. This is intriguing and should be explored further.

An analysis of these therapies revealed some common features which are now suggested as core requirements for all effective psychotherapeutic treatments:

An update to the aforementioned Cochrane review [29] was published in 2013. The update focussed on the psychotherapies that are available for the treatment of BPD and included a total

of 1804 participants spread over 28 studies. The psychotherapies discussed were divided into 'comprehensive' if they substantially involved an individual psychotherapy element or as 'non-comprehensive' if they did not. The comprehensive therapies included dialectical behaviour therapy, mentalization-based therapy (delivered in either a partial hospitalisation or outpatient setting), transference-focussed therapy, cognitive behavioural therapy, dynamic deconstructive psychotherapy, interpersonal psychotherapy and interpersonal therapy for BPD. These were assessed against a control condition and also with some direct comparisons against each other. Non-comprehensive psychotherapies included DBT-group skills training, emotion regulation group therapy, schema-focussed group therapy, systems training for emotional predictability and problem solving for borderline personality disorder (STEPPS), STEPPS plus individual therapy, manual assisted cognitive treatment, and psychoeducation[37].

Figure 3: Five common characteristics of evidence-based treatments for BPD [35, 36].

1. Structured (manual directed) approaches to prototypic BPD problems
2. Patients are encouraged to assume control of themselves (i.e. sense of self-agency)
3. Therapists help connections of feelings to events and actions
4. Therapists are active, responsive, and validating
5. Therapists discuss cases with others, (including personal reactions)

The authors concluded that both comprehensive and non-comprehensive therapies indicated beneficial effects for the core pathology of BPD and associated general psychopathology. The authors identified that dialectical behaviour therapy had been studied the most comprehensively followed by mentalization-based therapy, transference-focussed therapy, schema-focussed therapy and STEPPS. However, the authors do state that none of the treatments presented a very robust evidence base and that there are concerns over the quality of individual studies [37].

In terms of pharmacotherapy, the NICE and NHMRC guidelines agree with the 2006 Cochrane interventional review among others [38, 39] that there is some evidence that some second-generation antipsychotics (aripriprazole and olanzapine) and some mood stabilisers (topiramate, lamotrigine and valproate) could improve BPD symptoms in the short term. However, for some of these agents, it is necessary to balance risks against benefits as they have considerable long-term risks (e.g. with antipsychotics, extrapyramidal side effects such as tardive dyskinesia can persist even after withdrawal of the drug[40]). Such risks are not a problem in psychological treatments and it is probable that this influences guidelines. In practice, off-label use of psychotropics is widespread, despite the fact that the NICE guidance negates their use. It is arguable that clinicians should preferentially use pharmacological treatments that have the strongest evidence base (i.e. antipsychotics and mood stabilisers) and refrain from using agents with the least evidence (i.e. antidepressants and benzodiazepines).

CONCLUSION

Specialist treatments, in particular DBT and MBT substantiate the use of psychotherapy in BPD and these findings support the validity of the NICE guidance. However, the array of such treatments must be amalgamated with the view to provide a comprehensive, multi-faceted treatment approach. Each treatment must be broken down in order to outline the components that are particularly useful in BPD with the view to understand the condition in greater depth and to provide more focussed therapies.

The 2013 Cochrane review [37] highlights that further psychotherapies are available and have been shown to successfully treat BPD core pathology, however, as it is clearly stated the evidence base lacks robustness and there is a need for further studies that can replicate results. The therapies that have been included in this Cochrane review that have not been covered in the guidelines (e.g. STEPPS) may prove to be superior to those put forward by NICE, and I recommend that these be explored thoroughly when the guidelines are due for update.

While the NICE guidance emphasises that the use of psychotropics is reasonable in the management of comorbidities, it worth noting that to understand BPD, it is necessary to explore both the underlying aberrant psychological processes and biological processes that manifest in the disorder. This will enable the use of more specific pharmacological therapies in targeting the symptoms of BPD in the future.

Competing Interests
None declared

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