

# THE AMERICAN PSYCHIATRIC ASSOCIATION PRACTICE GUIDELINE FOR THE TREATMENT OF PATIENTS WITH BORDERLINE PERSONALITY DISORDER

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## Guideline Writing Group

George A. Keepers, M.D. (Chair)  
Laura J. Fochtmann, M.D., M.B.I. (Vice-Chair;  
Methodologist)  
Joan M. Anzia, M.D.  
Sheldon Benjamin, M.D.  
Jeffrey M. Lyness, M.D.  
Ramin Mojtabai, M.D.  
Mark Servis, M.D.  
Lois Choi-Kain, M.D.  
Kaz J. Nelson, M.D.  
John M. Oldham, M.D.  
Carla Sharp, Ph.D.  
Amanda Degenhardt, M.D.

## Systematic Review Group

Laura J. Fochtmann, M.D., M.B.I.  
(Methodologist)  
John M. Oldham, M.D.  
Seung-Hee Hong

## Committee on Practice Guidelines

Daniel J. Anzia, M.D., Chair  
R. Scott Benson, M.D.  
Oscar G. Bukstein, M.D.  
Catherine Crone, M.D.  
Jacqueline Posada, M.D.  
Michael J. Vergare, M.D.  
Ilse Wiechers, M.D.  
Muniza Majoka, M.D., Corresponding Member  
Saundra Stock, M.D., Corresponding Member  
Rochelle Woods, M.D., Corresponding Member

Joel Yager, M.D., Corresponding Member  
Laura J. Fochtmann, M.D., M.B.I., Consultant

## APA Assembly Liaisons

Daniel Dahl, M.D.  
Evan Eyler, M.D.  
Harold Ginsburg, M.D.  
Jason W. Hunziker, M.D.  
Marvin Koss, M.D.  
Lisa Schock, M.D.  
Ilse Wiechers, M.D.  
Brian Zimnitsky, M.D.

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## Acronyms/Abbreviations

ADHD	Attention-deficit/hyperactivity disorder	HIPAA	Health Insurance Portability and Accountability Act
AHRQ	Agency for Healthcare Research and Quality	ICD-10	International Statistical Classification of Diseases and Related Health Problems, 10th Revision
AMPD	Alternative model for personality disorders	LAI	Long-acting injectable
APA	American Psychiatric Association	LPFS-BF	Level of Personality Functioning Scale-Brief Form 2.0
ASD	Autism spectrum disorder	MAOIs	Monoamine oxidase inhibitors
AUD	Alcohol use disorder	MBT	Mentalization-based treatment
BEST	Borderline Evaluation of Severity Over Time	MDD	Major depressive disorder
BPD	Borderline personality disorder	OCD	Obsessive-compulsive disorder
BSL-23	Borderline Symptom List 23-item	PROMIS	Patient-Reported Outcomes Measurement Information System
CBT	Cognitive-behavioral therapy	PTSD	Posttraumatic stress disorder
DBT	Dialectical behavior therapy	RCT	Randomized controlled trial
DDP	Dynamic deconstructive psychotherapy	SFT	Schema-focused therapy
DERS	Difficulty in Emotional Regulation Scale	SOFAS	Social and Occupational Functioning Assessment Scale
DSHI	Deliberate Self-Harm Inventory	SSRIs	Selective serotonin reuptake inhibitors
DSM	Diagnostic and Statistical Manual of Mental Disorders	STEPPS	Systems Training for Emotional Predictability and Problem Solving
DSM-5-TR	Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, Text Revision	SUD	Substance use disorder
ECT	Electroconvulsive therapy	TFP	Transference-focused psychotherapy
EMDR	Eye movement desensitization and reprocessing	TMS	Transcranial magnetic stimulation
GPM	Good psychiatric management	WHODAS 2.0	World Health Organization Disability Schedule 2.0
GRADE	Grading of Recommendations Assessment, Development and Evaluation		

ZAN-BPD      Zanarini Rating Scale for  
Borderline Personality Disorder

## Introduction

### Rationale

The goal of this guideline is to improve the quality of care and treatment outcomes for patients with borderline personality disorder (BPD) as defined in Section II of the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, Text Revision (DSM-5-TR; American Psychiatric Association 2022a). Since publication of the last American Psychiatric Association (APA) practice guideline (American Psychiatric Association 2001) and guideline watch on BPD (Oldham 2005), there have been many studies on psychotherapies for individuals with BPD as well as some studies on pharmacotherapies. Despite this, there are still misconceptions about BPD (Baker and Beazley 2022; Masland et al. 2023; Proctor et al. 2021; Sheehan et al. 2016; Stiles et al. 2023) and substantial gaps in the availability of evidence-based treatments for individuals with BPD (Iliakis et al. 2019; Lohman et al. 2017). This practice guideline aims to help clinicians improve the care and well-being of their patients by reviewing current evidence and providing evidence-based statements that are intended to enhance knowledge and optimize treatment of BPD.

BPD is characterized in DSM-5-TR as being associated with a long-term pattern of instability of interpersonal relationships, unstable self-image, marked impulsivity, and/or affective instability (American Psychiatric Association 2022a). In addition, these features can be evidenced by efforts to avoid real or feared abandonment, chronic feelings of emptiness, mood reactivity, recurrent self-injurious or suicidal behavior, other impulsive behaviors with potential for self-damaging effects, intense anger or difficulty with anger control, and transient paranoid ideation or stress-related dissociative symptoms (American Psychiatric Association 2022a).

As with personality disorders in general, the pattern of inner experience and behavior with BPD can be quite heterogeneous but is relatively pervasive and enduring (American Psychiatric Association 2022a). Symptom onset may extend back to early adolescence although the diagnosis of BPD may not be made until later in adolescence or adulthood (American Psychiatric Association 2022a). In addition, it occurs across a broad range of personal and social situations, is markedly different from the expectations of the individual's culture or societal norms, and leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning (American Psychiatric Association 2022a). Although co-occurring conditions are common, the specific features of the personality disorder are not better explained by the effects of a substance, another psychiatric disorder, or another medical disorder (American Psychiatric Association 2022a).

The lifetime prevalence of BPD in the United States is approximately 1.4%-2.7%, although estimates can vary depending on the study location, sample demographic characteristics, and case finding and diagnostic approaches (Ellison et al. 2018; Grant et al. 2008; Leichsenring et al. 2023; Lenzenweger et al. 2007; Trull et al. 2010; Volkert et al. 2018; Winsper et al. 2020). In clinical populations, women are more frequently diagnosed with BPD and tend to seek treatment more often than men; however, non-clinical samples suggest that the prevalence of BPD is likely to be comparable in men and women (Busch et al. 2016; Lenzenweger et al. 2007; Zanarini et al. 2011a). Few studies have assessed the prevalence of BPD

in LGBTQ+ individuals (Denning et al. 2022; Rodriguez-Seijas et al. 2021). An estimated three-quarters of patients with BPD seek help from professional mental health services (Tomko et al. 2014). In clinical psychiatric populations, the prevalence of BPD is high and estimated at 10%-18% for outpatients and 9%-25% for inpatients (Doering 2019; Ellison et al. 2018; Gunderson 2009; Torgersen 2005; Volkert et al. 2018; Zimmerman et al. 2017). Individuals with BPD are also frequent users of primary care (Doering 2019) and have elevated rates of chronic pain and other somatic conditions (El-Gabalawy et al. 2010; Heath et al. 2018b; Sansone and Sansone 2012; Tate et al. 2022). The lifetime prevalence of BPD among primary care patients is about four times as high as in the general population (Gross et al. 2002). A high prevalence of BPD (21%) was also found among veterans receiving care in U.S. Veteran's Health Centers (Edwards et al. 2022).

Individuals with BPD commonly suffer from other psychiatric disorders such as major depressive disorder (MDD), bipolar disorder, posttraumatic stress disorder (PTSD), anxiety disorders, eating disorders, attention-deficit/hyperactivity disorder (ADHD), substance use disorders (SUDs), and other personality disorders (Choi-Kain et al. 2022; Friborg et al. 2014; Geluk Rouwhorst et al. 2022; Grant et al. 2016; Gunderson et al. 2014; Keuroghlian et al. 2015; Leichsenring et al. 2011; Lenzenweger et al. 2007; McDermid et al. 2015; McGlashan et al. 2000; Miller et al. 2022; Momen et al. 2022; Philipsen et al. 2008; Santo et al. 2022; Tate et al. 2022; Trull et al. 2018; Zanarini et al. 2004a, 2010, 2019; Zimmerman et al. 2017). Most individuals with BPD will actually present for treatment of another disorder, such as a mood or anxiety disorder (Zimmerman et al. 2017). Furthermore, when a co-occurring disorder is present, the clinical presentation may be more severe and symptom remission is often more difficult to achieve in the co-occurring disorder (Ceresa et al. 2021; Geluk Rouwhorst et al. 2022; Gunderson et al. 2014; Keuroghlian et al. 2015; Skodol et al. 2011).

The lifetime burden and psychosocial impairment associated with BPD can be substantial because it typically has an onset in adolescence or early adulthood and can persist for many years (American Psychiatric Association 2022a; Doering 2019; Leichsenring et al. 2011; Oldham 2006). The lived experience of BPD can be associated with significant emotional pain and a diminished quality of life (Botter et al. 2021; Miller et al. 2021; Ng et al. 2019a, 2019b). Disruptions in relationships, including with family, friends, and intimate partners are common (Ng et al. 2019a, 2019b). Individuals with BPD may also experience disruptions in schooling, employment, and housing (Juurink et al. 2019; Ng et al. 2019a, 2019b; Soloff 2021). Economic stability and productivity can be affected for those with BPD as well as for family members (Hastrup et al. 2019; Kay et al. 2018; Soloff 2021). In addition, individuals with BPD experience increases in health care costs related to BPD and to other physical conditions (Hastrup et al. 2019). These increases in costs can affect access to treatment, and in turn, affect health and quality of life (Lohman et al. 2017). Some studies suggest that individuals with BPD have an increased possibility of contacts with the criminal justice system (Dean et al. 2020; Nakic et al. 2022; Tate et al. 2022). Conversely, there are strong associations between having a diagnosis of BPD and being the victim of a violent crime (Tate et al. 2022). These significant consequences of BPD support a need for early identification and treatment.

In contrast to earlier views on BPD, this condition can remit, and BPD symptoms can be reduced and managed. Most individuals with BPD will experience some decline of symptoms during adulthood

(Gunderson et al. 2011; Stone 2017; Zanarini et al. 2012) and, in clinical samples, about 85% of individuals with BPD will no longer meet the threshold for diagnosis within 10 years of longitudinal follow-up (Gunderson et al. 2011; Stone 2017; Zanarini et al. 2012). Nevertheless, specific symptoms such as fear of abandonment, impulsivity, intense anger, and an unstable self-image may persist. Individuals with BPD may also continue to experience impairments in social (Gunderson et al. 2011) and occupational functioning (Niesten et al. 2016) and may have a need for ongoing treatment.

Rates of suicide attempts and episodes of self-harm also decline over time (Zanarini et al. 2008), but they continue to occur more often than in individuals without BPD (Grilo and Udo 2021; Yen et al. 2021; Zanarini et al. 2008). Furthermore, in longitudinal studies, BPD is associated with increases in deaths due to suicide as well as all-cause mortality (Kjær et al. 2020; Paris 2019; Schneider et al. 2019; Temes et al. 2019). Accordingly, an overall goal of this guideline is to enhance the assessment and treatment of BPD, thereby reducing the mortality, morbidity, and significant psychosocial and health consequences of this important psychiatric condition.

An additional rationale for this practice guideline is to provide clinicians with the necessary knowledge to feel confident in their skills for treating patients with BPD. A considerable amount of stigma exists in relation to BPD, including self-stigma, and patients with BPD often experience discrimination within the health care system (Baker and Beazley 2022; Masland et al. 2023; Proctor et al. 2021; Stiles et al. 2023). Bias about BPD is lessened and empathy for patients is increased when clinicians have received education about working with individuals with BPD (e.g., through seminars on good psychiatric management [GPM]; Keuroghlian et al. 2016; Klein et al. 2022b; Masland et al. 2018). It is also important for clinicians to gain perspectives on the lived experiences of individuals with BPD. Other misconceptions about BPD can also be corrected through education. For example, one misconception is that BPD only occurs in adults; however, adolescents can meet criteria for BPD and can benefit from treatment aimed at addressing BPD core features and symptoms (Bo et al. 2021; Ilagan and Choi-Kain 2021; Sharp 2017; Weiner et al. 2018; Winsper 2021). Education can also be helpful in emphasizing that treatment of BPD is effective and that many patients with BPD will improve with treatment (Bohus et al. 2021; Gunderson et al. 2011; Leichsenring et al. 2023; Stone 2017; Zanarini et al. 2012). Consequently, this guideline also aims to improve the quality of care for individuals with BPD by providing clinicians with up-to-date knowledge of treating BPD.

## Scope of Document

This practice guideline focuses on evidence-based treatments for BPD. In addition, it includes statements related to assessment and treatment planning, which are an integral part of patient-centered care.

## Scope Constraints Related to the Systematic Review of Evidence

The scope of this document is shaped by recent diagnostic criteria for BPD as defined by DSM-IV, DSM-IV-TR, DSM-5, or ICD-10 and by the available evidence. The document scope is also affected by a number of limitations of the evidence as obtained by a systematic review of the literature through September 2021. For example, most studies reported the sex of participants but not their gender identity. Most studies also included a greater proportion of women than men and enrolled predominantly white



participants; however, many studies did not specify the racial, ethnic, or cultural characteristics of the sample. Our review included research with participants aged 13 and older, and some studies were focused specifically on adolescents. Other studies primarily included adult populations or did not analyze data based on age. Furthermore, key issues of relevance to adolescents and emerging adults such as family relationships and trajectories of psychosocial development were not systematically assessed. These gaps emphasize the compelling need for additional research in more representative samples.

The lived experience of individuals with BPD is another crucial topic where research has been sparse, both in terms of BPD symptoms and impact and in terms of treatment related experiences and the ways in which these experiences may influence treatment outcomes.

Data are also limited on treatment of individuals with BPD and significant physical health conditions or co-occurring psychiatric conditions, including SUDs. Many of the available studies of BPD did not analyze data separately for these patient subgroups or excluded individuals with these comorbidities. Few studies were specifically aimed at effectiveness of treatment in individuals with BPD and a co-occurring condition. Nevertheless, in the absence of more robust evidence, the statements in this guideline should generally be applicable to individuals with co-occurring conditions.

Our systematic review did not include studies related to risk factors of BPD, prevention of BPD, non-suicidal self-injury in the absence of other BPD features, or complex PTSD. It also did not include search terms to identify literature on stigma and discrimination, either as risk factors for BPD, contributors to morbidity, or barriers to seeking treatment. Each of these topics is important but would warrant a distinct systematic review from one focused on treatments for BPD.

Cost-effectiveness considerations and availability of specific treatments are also outside of the scope of this guideline. Although treatment availability and cost are often barriers to receiving treatment, each of these factors typically differs by country and geographic region and vary widely with the health system and payment model. In addition, few high-quality studies exist on the cost-effectiveness of treatments for BPD that could be used to inform health care policy.

Finally, we do not discuss telehealth as a specific intervention as there were no direct comparisons of telehealth and in-person care that met the inclusion criteria for the systematic review. There is, however, a rapidly expanding literature on the use of telehealth, web-based interventions, and mobile apps in psychiatric treatment, which will help to inform future practice guidelines.

#### Scope Constraints Related to the Alternative DSM-5 Model for Personality Disorders

We recognize that the Alternative DSM-5 Model for Personality Disorders (AMPD; DSM-5-TR, Section III: Emerging Measures and Models, American Psychiatric Association 2022a) has had a significant impact in the realm of personality disorder assessment (Krueger and Hobbs 2020; Zimmermann et al. 2019) and is useful in adolescents as well as adults (Sharp et al. 2022). The AMPD is increasingly being integrated into clinical practice (Bach and Tracy 2022; Milinkovic and Tiliopoulos 2020; Oldham 2022a). From both diagnostic and treatment standpoints, it is helpful to determine whether core impairments are present in self-functioning (i.e., identity and self-direction) and in interpersonal functioning (i.e., empathy and

intimacy) (American Psychiatric Association 2022a; Sharp and Wall 2021). Despite the growing recognition of the importance of the AMPD, our systematic review did not identify treatment studies using the AMPD that met our inclusion criteria. Thus, we are including the AMPD as an area that requires further treatment-related research, but we have not incorporated it into our recommendations in this version of the practice guideline.

### Overview of the Development Process

Since the publication of the Institute of Medicine (now known as National Academy of Medicine) report, *Clinical Practice Guidelines We Can Trust* (Institute of Medicine 2011), there has been an increasing focus on using clearly defined, transparent processes for rating the quality of evidence and the strength of the overall body of evidence in systematic reviews of the scientific literature. This guideline was developed using a process intended to be consistent with the recommendations of the Institute of Medicine (Institute of Medicine 2011) and *the Principles for the Development of Specialty Society Clinical Guidelines* of the Council of Medical Specialty Societies (2017). Parameters used for the guideline's systematic review are included with the full text and the appendices of the guideline; the development process is fully described in the following document available on the APA Web site:

<https://www.psychiatry.org/psychiatrists/practice/clinical-practice-guidelines/guideline-development-process>.

### Rating the Strengths of Guideline Statements and Supporting Research Evidence

Development of guideline statements entails weighing the potential benefits and harms of the statement and then identifying the level of confidence in that determination. This concept of balancing benefits and harms to determine guideline recommendations and strength of recommendations is a hallmark of GRADE (Grading of Recommendations Assessment, Development and Evaluation), which is used by many professional organizations around the world to develop practice guideline recommendations (Guyatt et al. 2013). With the GRADE approach, recommendations are rated by assessing the confidence that the benefits of the statement outweigh the harms and burdens of the statement, determining the confidence in estimates of effect as reflected by the quality of evidence, estimating patient values and preferences (including whether they are similar across the patient population), and identifying whether resource expenditures are worth the expected net benefit of following the recommendation (Andrews et al. 2013).

In weighing the balance of benefits and harms for each statement in this guideline, our level of confidence is informed by available evidence, which includes evidence from clinical trials as well as expert opinion and patient values and preferences. Evidence for the benefit of a particular intervention within a specific clinical context is identified through systematic review and is then balanced against the evidence for harms. In this regard, harms are broadly defined and may include serious adverse events, less serious adverse events that affect tolerability, minor adverse events, negative effects of the intervention on quality of life, barriers and inconveniences associated with treatment, direct and indirect costs of the intervention (including opportunity costs), and other negative aspects of the treatment that may influence decision making by the patient, the clinician, or both.

Many topics covered in this guideline have relied on forms of evidence such as consensus opinions of experienced clinicians or indirect findings from observational studies rather than research from randomized trials. It is well recognized that there are guideline topics and clinical circumstances for which high-quality evidence from clinical trials is not possible or is unethical to obtain (Council of Medical Specialty Societies 2017). For example, many questions need to be asked as part of an assessment and inquiring about a particular symptom or element of the history cannot be separated out for study as a discrete intervention. It would also be impossible to separate changes in outcomes due to assessment from changes in outcomes due to ensuing treatment. Research on psychiatric assessments and some psychiatric interventions can also be complicated by multiple confounding factors such as the interaction between the clinician and the patient or the patient’s unique circumstances and experiences. The GRADE working group and guidelines developed by other professional organizations have noted that a strong recommendation or “good practice statement” may be appropriate even in the absence of research evidence when sensible alternatives do not exist (Andrews et al. 2013; Brito et al. 2013; Djulbegovic et al. 2009; Hazlehurst et al. 2013). For each guideline statement, we have described the type and strength of the available evidence as well as the factors, including patient preferences, that were used in determining the balance of benefits and harms.

The authors of the guideline determined each final rating, as described in the section “Guideline Development Process” that is endorsed by the APA Board of Trustees. A *recommendation* (denoted by the numeral 1 after the guideline statement) indicates confidence that the benefits of the intervention clearly outweigh harms. A *suggestion* (denoted by the numeral 2 after the guideline statement) indicates greater uncertainty. Although the benefits of the statement are still viewed as outweighing the harms, the balance of benefits and harms is more difficult to judge, or either the benefits or the harms may be less clear. With a suggestion, patient values and preferences may be more variable, and this can influence the clinical decision that is ultimately made. Each guideline statement also has an associated rating for the *strength of supporting research evidence*. Three ratings are used: *high*, *moderate*, and *low* (denoted by the letters A, B, and C, respectively) and reflect the level of confidence that the evidence for a guideline statement reflects a true effect based on consistency of findings across studies, directness of the effect on a specific health outcome, precision of the estimate of effect, and risk of bias in available studies (Agency for Healthcare Research and Quality 2014; Balshem et al. 2011; Guyatt et al. 2006).

Table 1. Rating the strengths of guideline statements and evidence for guideline statements.

Strength of guideline statement			Strength of evidence		
1	Recommendation	Denotes confidence that the benefits of the intervention clearly outweigh the harms.	A	High confidence	Further research is very unlikely to change the estimate of effect and our confidence in it.
2	Suggestion	Denotes benefits that are viewed as outweighing harms, but the balance is	B	Moderate confidence	Further research may change the estimate of effect and our confidence in it.

		more difficult to judge and patient values and preferences may be more variable.			
			C	Low confidence	Further research is likely to change the estimate of effect and our confidence in it.

### Proper Use of Guidelines

The APA Practice Guidelines are assessments of current (as of the date of authorship) scientific and clinical information provided as an educational service. The guidelines 1) do not set a standard of care and are not inclusive of all proper treatments or methods of care; 2) are not continually updated and may not reflect the most recent evidence, as new evidence may emerge between the time information is developed and when the guidelines are published or read; 3) address only the question(s) or issue(s) specifically identified; 4) do not mandate any particular course of medical care; 5) are not intended to substitute for the independent professional judgment of the treating clinician; and 6) do not account for individual variation among patients. As such, it is not possible to draw conclusions about the effects of omitting a particular recommendation, either in general or for a specific patient. Furthermore, adherence to these guidelines will not ensure a successful outcome for every individual, nor should these guidelines be interpreted as including all proper methods of evaluation and care or excluding other acceptable methods of evaluation and care aimed at the same results. The ultimate recommendation regarding a particular assessment, clinical procedure, or treatment plan must be made by the clinician directly involved in the patient’s care in light of the psychiatric evaluation, other clinical data, and the diagnostic and treatment options available. Such recommendations should be made in collaboration with the patient, whenever possible, and incorporate the patient’s personal and sociocultural preferences and values in order to enhance the therapeutic alliance, adherence to treatment, and treatment outcomes. For all of these reasons, the APA cautions against the use of guidelines in litigation. Use of these guidelines is voluntary. APA provides the guidelines on an “as is” basis and makes no warranty, expressed or implied, regarding them. APA assumes no responsibility for any injury or damage to persons or property arising out of or related to any use of the guidelines or for any errors or omissions.

## Guideline Statement Summary

### Assessment and Determination of Treatment Plan

1. APA *recommends (1C)* that the initial assessment of a patient with possible borderline personality disorder include the reason the individual is presenting for evaluation; the patient's goals and preferences for treatment; a review of psychiatric symptoms, including core features of personality disorders and common co-occurring disorders; a psychiatric treatment history; an assessment of physical health; an assessment of psychosocial and cultural factors; a mental status examination; and an assessment of risk of suicide, self-injury, and aggressive behaviors, as outlined in APA's Practice Guidelines for the Psychiatric Evaluation of Adults (3rd edition).
2. APA *suggests (2C)* that the initial psychiatric evaluation of a patient with possible borderline personality disorder include a quantitative measure to identify and determine the severity of symptoms and impairments of functioning that may be a focus of treatment.
3. APA *recommends (1C)* that a patient with borderline personality disorder have a documented, comprehensive, and person-centered treatment plan.
4. APA *recommends (1C)* that a patient with borderline personality disorder be engaged in a collaborative discussion about their diagnosis and treatment, which includes psychoeducation related to borderline personality disorder.

### Psychosocial Interventions

5. APA *recommends (1B)* that a patient with borderline personality disorder be treated with a structured approach to psychotherapy that has support in the literature and targets the core features of the disorder.

### Pharmacotherapy

6. APA *recommends (1C)* that a patient with borderline personality disorder have a review of co-occurring disorders, prior psychotherapies, other non-pharmacological treatments, past medication trials, and current medications before initiating any new medication.
7. APA *suggests (2C)* that any psychotropic medication treatment of borderline personality disorder be time-limited, aimed at addressing a specific measurable target symptom, and adjunctive to psychotherapy.
8. APA *recommends (1C)* that a patient with borderline personality disorder have a review and reconciliation of their medications at least every 6 months to assess the effectiveness of treatment and identify medications that warrant tapering or discontinuation.

## Guideline Statements and Implementation

### Assessment and Determination of Treatment Plan

#### Statement 1 – Initial Assessment

APA *recommends* **(1C)** that the initial assessment of a patient with possible borderline personality disorder include the reason the individual is presenting for evaluation; the patient’s goals and preferences for treatment; a review of psychiatric symptoms, including core features of personality disorders and common co-occurring disorders; a psychiatric treatment history; an assessment of physical health; an assessment of psychosocial and cultural factors; a mental status examination; and an assessment of risk of suicide, self-injury, and aggressive behaviors, as outlined in APA’s Practice Guidelines for the Psychiatric Evaluation of Adults (3rd edition).

#### *Implementation*

The importance of the psychiatric evaluation cannot be underestimated because it serves as the initial basis for a therapeutic relationship with the patient and provides information that is crucial to differential diagnosis and shared decision-making about treatment. The initial evaluation can also provide an opportunity for educating patients, family members, friends, or others involved in the patient’s care about such factors as BPD features, treatments, course, and prognosis. APA’s Practice Guidelines for the Psychiatric Evaluation of Adults, 3rd edition (American Psychiatric Association 2016a) describe recommended and suggested elements of assessment for any individual who presents with psychiatric symptoms (Table 2). These elements are by no means comprehensive, and additional areas of inquiry will become apparent as the evaluation unfolds, depending on the responses to initial questions, the presenting concerns, the observations of the clinician during the assessment, the complexity and urgency of clinical decision-making, and other aspects of the clinical context. In many circumstances, aspects of the evaluation will extend across multiple visits (American Psychiatric Association 2016a).

*Table 2. Recommended aspects of the initial psychiatric evaluation.*

### **History of Present Illness**

- Reason that the patient is presenting for evaluation, including current symptoms, behaviors, and precipitating factors
- Current psychiatric diagnoses and psychiatric review of systems

### **Psychiatric History**

- Hospitalization and emergency department visits for psychiatric issues, including substance use disorders
- Psychiatric treatments (type, duration, and, where applicable, doses)
- Response and adherence to psychiatric treatments, including psychosocial treatments, pharmacotherapy, and other interventions such as electroconvulsive therapy or transcranial magnetic stimulation
- Prior psychiatric diagnoses and symptoms including:
  - Hallucinations (including command hallucinations), delusions, and negative symptoms
  - Aggressive ideas or behaviors (e.g., homicide, domestic or workplace violence, other physically or sexually aggressive threats or acts)
  - Impulsivity
  - Suicidal ideas, suicide plans, and suicide attempts, including details of each attempt (e.g., context, method, damage, potential lethality, intent) and attempts that were aborted or interrupted
  - Intentional self-injury in which there was no suicide intent

### **Substance Use History**

- Use of tobacco, alcohol, and other substances (e.g., vaping, marijuana, cocaine, heroin, hallucinogens) and any misuse of prescribed or over-the-counter medications or supplements
- Current or recent substance use disorder or change in use of alcohol or other substances

### **Medical History**

- Whether or not the patient has an ongoing relationship with a primary care health professional
- Allergies or drug sensitivities
- All medications the patient is currently or recently taking and the side effects of these medications (i.e., both prescribed and nonprescribed medications, herbal and nutritional supplements, and vitamins)
- Past or current medical illnesses and related hospitalizations
- Relevant past or current treatments, including surgeries, other procedures, or complementary and alternative medical treatments
- Sexual and reproductive history
- Cardiopulmonary status
- Past or current neurological or neurocognitive disorders or symptoms
- Past physical trauma, including head injuries
- Past or current endocrinological disease
- Past or current infectious disease, including sexually transmitted diseases, HIV, tuberculosis, hepatitis C, and locally endemic infectious diseases such as Lyme disease
- Past or current sleep abnormalities, including sleep apnea
- Past or current symptoms or conditions associated with significant pain and discomfort
- Additional review of systems, as indicated

### **Family History**

- Including history of suicidal behaviors or aggressive behaviors in biological relatives

### **Personal and Social History**

- Preferred language and need for an interpreter
- Personal/cultural beliefs, sociocultural environment and cultural explanations of psychiatric illness
- Presence of psychosocial stressors (e.g., financial, housing, legal, school/occupational, or interpersonal/relationship problems; lack of social support; painful, disfiguring, or terminal medical illness)
- Exposure to physical, sexual, or emotional trauma
- Exposure to violence or aggressive behavior, including combat exposure or childhood abuse
- Legal or disciplinary consequences of past aggressive behaviors

### **Examination, Including Mental Status Examination**

- General appearance and nutritional status
- Height, weight, and body mass index (BMI)
- Vital signs
- Skin, including any stigmata of trauma, self-injury, or drug use
- Coordination and gait
- Involuntary movements or abnormalities of motor tone
- Sight and hearing
- Speech, including fluency and articulation
- Mood, degree of hopelessness, and level of anxiety
- Thought content, process, and perceptions, including current hallucinations, delusions, negative symptoms, and insight
- Cognition
- Current suicidal ideas, suicide plans, and suicide intent, including active or passive thoughts of suicide or death
  - If current suicidal ideas are present, assess: patient's intended course of action if current symptoms worsen; access to suicide methods including firearms; patient's possible motivations for suicide (e.g., attention or reaction from others, revenge, shame, humiliation, delusional guilt, command hallucinations); reasons for living (e.g., sense of responsibility to children or others, religious beliefs); and quality and strength of the therapeutic alliance.
- Current aggressive ideas, including thoughts of physical or sexual aggression or homicide
  - If current aggressive ideas are present, assess: specific individuals or groups toward whom homicidal or aggressive ideas or behaviors have been directed in the past or at present; impulsivity, including anger management issues and access to firearms

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Source. Adapted from APA's Practice Guidelines for the Psychiatric Evaluation of Adults, 3rd Edition. Arlington VA, American Psychiatric Association, 2016. Copyright © 2016 American Psychiatric Association. Used with permission.

The specific approach to the interview will depend on many factors, including the patient's ability to communicate, degree of cooperation, level of insight, illness severity, and ability to recall historical details (American Psychiatric Association 2016a). Such factors as the patient's health literacy (Clausen et al. 2016) and cultural background (Lewis-Fernández et al. 2016) can also influence the patient's understanding or interpretation of questions. Typically, a psychiatric evaluation involves a direct



interview between the patient and the clinician (American Psychiatric Association 2016a). The use of open-ended empathic questions about the patient's current life circumstances and reasons for evaluation can provide an initial picture of the individual and serve as a way of establishing rapport. Such questions can be followed up with additional structured inquiry about history, symptoms, or observations made during the assessment.

A respectful and empathic approach to the interview is important because patients may have had prior experiences with stigma or bias in health care settings or may have self-stigmatizing views (Denning et al. 2022; Goldhammer et al. 2019; Klein et al. 2022a; Masland et al. 2023; McKenzie et al. 2022; Olbert et al. 2018; Rodriguez-Seijas et al. 2023; Schwartz and Blankenship 2014; Stiles et al. 2023; Zimmerman et al. 2022). These biases, stigma, and self-stigma can also influence assessment and diagnosis related to BPD (Klein et al. 2022a; Masland et al. 2023; McKenzie et al. 2022; Stiles et al. 2023). In addition, disparities in assessment and diagnosis based on race or gender identity are common (Denning et al. 2022; Goldhammer et al. 2019; Masland et al. 2023; Olbert et al. 2018; Rodriguez-Seijas et al. 2021; Schwartz and Blankenship 2014; Zimmerman et al. 2022).

Many individuals with BPD will also have had traumatic experiences during their lifetime such as childhood maltreatment, sexual trauma, or violent victimization (de Aquino Ferreira et al. 2018; Hailes et al. 2019; Porter et al. 2020; Tate et al. 2022). Sensitivity to the impact of these experiences, including use of trauma-informed approaches, can aid in establishing a supportive environment that is conducive to rapport (Burns et al. 2023; Center for Substance Abuse Treatment (US) 2014; Huo et al. 2023; Menschner and Maul 2016; National Council for Mental Wellbeing 2019; Raja et al. 2015; Rudolph 2021; Saunders et al. 2023; Substance Abuse and Mental Health Services Administration 2014). Depending on the circumstances of the initial evaluation, it may be preferable to defer discussion of prior traumatic experiences until a therapeutic relationship is established or until the setting is more conducive to obtaining detailed information.

Throughout the assessment process, it is important to gain an understanding of the patient's goals, their view of the illness, and preferences for treatment. This information will serve as a starting point for person-centered care and shared decision-making with the patient, family, friends, and other persons involved in the patient's care (Dixon et al. 2016; Hamann and Heres 2019). It will also provide a framework for recovery, which has been defined as "a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential" (Substance Abuse and Mental Health Services Administration 2012, p. 3). Consequently, discussions of goals should be focused beyond symptom relief and may include goals related to schooling, employment, living situation, relationships, leisure activities, and other aspects of functioning and quality of life. Family context and educational factors are particularly crucial to identify when assessing adolescents and emerging adults. Questions about the patient's views may help determine whether the patient is aware of having an illness and assist in understanding the patient's explanations for or experience of their symptoms or distress (Saks 2009). Based on prior treatment experiences, patients may have specific views about such topics as medications, other treatment approaches, mechanical restraints, or involuntary treatment. It is also important to inquire about the patient's strengths and protective factors. For example, patients may be able to delineate strategies that have been helpful for

them in coping with or managing their symptoms in the past (Cohen et al. 2017). Some patients will have completed a psychiatric advance directive (Murray and Wortzel 2019) and, if so, it will be important to review that with the patient.

In addition to direct interview, patients may be asked to complete electronic or paper-based forms that ask about psychiatric symptoms or key aspects of the history (American Psychiatric Association 2016a). When available, prior medical records, electronic prescription databases, and input from other treating clinicians can add further details to the history or corroborate information obtained in the interview (American Psychiatric Association 2016a).

People with BPD have heterogeneous relationships with family members, friends, and other individuals. Often, family members, friends, or other individuals in the patient's support network can be an important part of the patient's care team. Such individuals can also serve as valuable sources of collateral information about the reason for evaluation, the patient's past history, and current symptoms and behavior (American Psychiatric Association 2016a). Input from and engagement of parents, guardians, or other caregivers is particularly important when assessing and treating adolescents and emerging adults. In other circumstances, a patient may not want a specific family member or other individual to be involved in their care. For example, a patient may wish to avoid burdening a loved one or may have experienced abuse by a particular family member in the past. A patient may also have felt unsupported by family members or others in terms of issues such as their life goals, their gender identity, coping with their BPD symptoms, or other aspects of their lives.

For these reasons, the patient's permission is typically obtained before outreach to family, friends, and others in the support network, except in emergent situations to prevent or lessen a serious and imminent threat to the health or safety of the patient or others (American Psychiatric Association 2013a, 2016a; Office for Civil Rights 2017). In addition, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA; Office for Civil Rights 2017), a clinician may listen to information provided by a family member or other involved person, as long as confidential information about the patient is not provided to that individual (American Psychiatric Association 2016a).

The initial evaluation will typically begin with the reason the individual is presenting for evaluation. Common concerns in individuals with BPD include anxiety, depression, mood instability, irritability, difficulties with anger, hopelessness, low self-esteem, unstable self-image or sense of self, unstable and intense interpersonal relationships, concerns about real or feared abandonment, suicidal thoughts or attempts, non-suicidal self-injury, other impulsive or self-harming behaviors (e.g., substance use, reckless driving, risky sexual behavior), or harm to others.

As part of the initial evaluation, it is useful to ask about the onset, course, and duration of symptoms. Features that are common in BPD and can aid in establishing a diagnosis include extreme responses to real or imagined abandonment, sudden shifts in their views of others, intense dysphoria, prominent mood reactivity, chronic feelings of emptiness, or intense anger (American Psychiatric Association 2022a). Other illness-driven behaviors, such as self-injurious behavior, may also be present. Specific questions may be needed to identify whether the patient has had transient dissociative experiences,

hallucinations, ideas of reference, or persecutory ideas, particularly in periods of stress (American Psychiatric Association 2022a). It is also helpful to determine whether impairments are present in self-functioning (i.e., identity and self-direction) and in interpersonal functioning (i.e., empathy and intimacy (American Psychiatric Association 2022a).

If the patient has received treatment previously, it is important to ask about a broad range of treatments and other approaches to addressing the patient's symptoms and functioning, and to specifically ask about the full range of treatment settings (e.g., outpatient, partial hospitalization, inpatient) and approaches or aspects of the therapeutic relationships that the patient has found helpful or problematic (American Psychiatric Association 2016a; Bachelor 2013; Barnicot et al. 2022; de Freixo Ferreira et al. 2023; Woodbridge et al. 2023). For example, prompting may be needed to learn information about the patient's experiences with psychotherapies (e.g., dialectical behavior therapy [DBT], cognitive-behavioral therapy [CBT], mentalization-based treatment [MBT], transference-focused psychotherapy [TFP], schema-focused therapy [SFT], dynamic deconstructive psychotherapy [DDP], other psychodynamic therapies, couples or family therapy, supportive therapy) as well as its format, frequency, and duration. A patient may believe that they have not responded to a specific type of psychotherapy, but the fidelity to key treatment principles (as described in the Implementation section of Statement 5) may have been limited or the treatment intensity or duration may have been insufficient. The formats and focus of the different psychotherapies may be a good fit for some individuals but not for others; for example, some but not all patients do well with the structure of homework assignments, some prefer individual treatment to groups, and some prefer insight-oriented approaches to skills-based approaches (Woodbridge et al. 2023). With medications, information on the specific medication, duration of treatment, formulation, route, and dose are important to obtain. Specific questions may be needed on long-acting injectable (LAI) medications (e.g., antipsychotics, naltrexone, buprenorphine) or implants (e.g., buprenorphine, contraceptive agents), over-the-counter medications, herbal products, or nutritional supplements because these medications may be overlooked by patients and are less likely to be included in pharmacy databases and patients' lists of active medications. Experimental treatments such as psilocybin and ketamine are increasingly available. Other interventions can include substance use treatments, neuromodulatory therapies (e.g., electroconvulsive therapy [ECT], transcranial magnetic stimulation [TMS]), court-ordered treatment, treatment while incarcerated, 12-step programs, self-help groups, culture-based approaches, spiritual healers, and complementary or alternative treatment approaches. For each specific type of intervention that the patient has received, it is important to learn more about the patient's response (including tolerability, changes in quality of life, level of functioning, symptom response/remission, and persistence of improvement) as well as their engagement in therapy and degree of adherence.

A thorough history is also important for identifying the presence of co-occurring psychiatric conditions or physical disorders that need to be addressed in treatment planning (American Psychiatric Association 2016a; Firth et al. 2019). Substance use and SUDs are common in individuals with BPD (Grant et al. 2008; Trull et al. 2018), and some individuals with BPD may use substances in an effort to cope with emotional distress or help regulate their emotions. Thus, a substance use history will be valuable in determining whether the patient uses tobacco, marijuana, or other substances such as alcohol, caffeine, nicotine,

cocaine, opioids, sedative-hypnotic agents, stimulants, 3,4-methylenedioxymethamphetamine (MDMA), solvents, androgenic steroids, hallucinogens, ketamine, or synthetic substances (e.g., “bath salts,” K2, Spice). The route by which substances are used (e.g., ingestion, smoking, vaping, intranasal, intravenous) and the frequency and circumstances of use are also important to document.

In addition to SUDs, other common co-occurring psychiatric conditions in individuals with BPD include MDD, bipolar disorder, PTSD, anxiety disorders, eating disorders, ADHD, and other personality disorders (Choi-Kain et al. 2022; Friborg et al. 2014; Geluk Rouwhorst et al. 2022; Grant et al. 2016; Gunderson et al. 2014; Keuroghlian et al. 2015; Leichsenring et al. 2011; Lenzenweger et al. 2007; McDermid et al. 2015; McGlashan et al. 2000; Miller et al. 2022; Momen et al. 2022; Philipsen et al. 2008; Santo et al. 2022; Tate et al. 2022; Trull et al. 2018; Zanarini et al. 2004a, 2010, 2019; Zimmerman et al. 2017). Individuals with BPD may also have physical health conditions, sleep disturbances, or chronic pain that need to be considered in assessing functioning and developing a plan of treatment (Doering 2019; El-Gabalawy et al. 2010; Heath et al. 2018b; Kalira et al. 2013; Sansone and Sansone 2012; Vanek et al. 2021; Winsper et al. 2017). Prior head trauma or other brain abnormalities (e.g., due to anoxic injury) can contribute to impulsivity or emotional dysregulation (McHugo et al. 2017).

The psychosocial history reviews the stages of the patient’s life and may include attention to perinatal events, delays in developmental milestones, disruptive behavioral disorders in childhood, childhood maltreatment (including neglect or emotional, physical, or sexual abuse), academic history and performance (including a history of being bullied, learning difficulties, special education interventions, or disciplinary actions), occupational history (including military history), legal history, and identification of major life events (e.g., adoption or foster care, family separation, parental loss, divorce, migration history, sexual trauma, other traumatic experiences) and psychosocial stressors (e.g., financial, housing, legal, school/occupational, or interpersonal/relationship problems; childcare or other caregiving responsibilities; lack of social support; trauma related to racial/ethnic discrimination; discrimination or trauma related to LGBTQ+ identity; painful, disfiguring, or terminal medical illness; other social determinants of health) (American Psychiatric Association 2016a; Barnhill 2014; MacKinnon et al. 2016; Smith et al. 2019). Information on the patient’s gender identity and pronouns is also important to elicit.

Individuals may have received disability-related income support, supported employment, or accommodations related to disability in academic, workplace, or other settings. Such accommodations are important to be aware of because they can help promote functioning and enhance integration into the community. If patients are eligible for disability-related income support, supported employment, or disability-related accommodations but have not received them, this will also be relevant to treatment planning. Furthermore, inquiring into an individual’s accommodation history can serve as a starting point for discussion on accessibility needs during treatment and assuring that these are met.

The patient’s history of interpersonal relationships, including family and intimate relationships, is particularly essential to obtain. Such relationships can be supportive and helpful, or they can be unstable or intense in individuals with BPD. The patient’s current and prior degree of interpersonal functioning (including in academic, occupational, social, and family roles, such as parenting) is similarly vital to the history and subsequent treatment planning. Assessment of interpersonal functioning should take

developmental considerations into account, particularly in adolescents and emerging adults. Information about the patient’s family constellation and other persons who provide support will serve as a foundation for working collaboratively with the patient and their support network. A family health history is also important in identifying family members with a history of personality disorder, particularly BPD or BPD traits, as well as the presence of SUDs, other psychiatric disorders, or suicidal behaviors in the family.

The cultural history is similarly integral to understanding the patient and developing an effective plan of treatment. In addition to emphasizing relationships, both familial and nonfamilial, it also delineates the role of important cultural, spiritual, and religious beliefs and practices in the patient’s life (Aggarwal and Lewis-Fernández 2015; American Psychiatric Association 2022b; Lewis-Fernández et al. 2016). The Cultural Formulation Interview (American Psychiatric Association 2022b) provides a framework for obtaining this information as part of the evaluation. Clinicians should be especially careful to avoid cultural bias when applying the diagnostic criteria and evaluating sexual behavior, expressions of emotion, suspiciousness, or impulsiveness, which may have different norms in different cultures or subcultures. Individuals from different cultures or with different spiritual or religious beliefs may also have different views of roles among family members and intimate partners as well as different views of and knowledge about health and mental health including diagnoses, treatments, attitudes, and beliefs towards the patient’s health and mental health issues.

The mental status examination is an essential part of the initial assessment. A full delineation of the mental status examination is beyond the scope of this document, and detailed information on conducting the examination is available elsewhere (American Psychiatric Association 2016a; Barnhill 2014; MacKinnon et al. 2016; Smith et al. 2019; Strub and Black 2000). In addition, for individuals with possible BPD, risk assessment is particularly important. It is crucial to identify past and current risks to self (e.g., suicidal ideas, methods, plans, and intent; non-suicidal self-injury; suicide attempts, including interrupted and aborted suicide attempts) and risks to others (e.g., aggressive or homicidal thoughts, statements, or behaviors). Information gathered and synthesized as part of the history and mental status examination will help identify modifiable risk factors for suicidal or aggressive behaviors that can serve as targets of intervention in constructing a plan of treatment. Inquiring about the patient’s degree of insight and judgment, as discussed above, will also provide information relevant to risk assessment, treatment outcomes, and adherence (Mintz et al. 2003; Mohamed et al. 2009).

#### Statement 2 – Quantitative Measures

APA *suggests* **(2C)** that the initial psychiatric evaluation of a patient with possible borderline personality disorder include a quantitative measure to identify and determine the severity of symptoms and impairments of functioning that may be a focus of treatment.

#### *Implementation*

A number of rating scales are available that have been used to identify and determine the severity of symptoms of BPD. Although rating scales have primarily been used in research contexts, they can also be used clinically to complement other aspects of the screening and assessment process (American Psychiatric Association 2016a).

Use of rating scales can aid treatment planning in several ways. Such measures provide a structured replicable way to document the patient’s baseline symptoms. They can also help to determine which symptoms should be the target of intervention on the basis of factors such as frequency of occurrence, magnitude, or impact on the patient’s functioning, well-being, and quality of life. As treatment proceeds, use of quantitative measures allows more precise tracking of whether psychotherapies or other treatments are having their intended effect or whether a shift in the treatment plan is needed (Lewis et al. 2019). The exact frequency of measures will depend on clinical circumstances. Nevertheless, it is preferable to use a consistent approach to quantitative measurement for a given patient because each rating scale defines and measures symptoms differently. In addition, patients’ ratings can be compared with family members’ impressions of treatment effects to clarify the longitudinal course of the patient’s illness.

When rating scales are used, they should always be implemented in a way that supports developing and maintaining the therapeutic relationship with the patient. Often, patient-rated scales are less time-consuming to administer than clinician-rated scales or structured or semi-structured interviews. The use of anchored, self-rated scales with criteria to assess the severity and frequency of symptoms can also help patients become more informed self-observers. In addition, they provide important insights into the patient’s experience that support person-centered care. Reviewing scale results with the patient can help foster a collaborative dialogue about progress toward symptom improvement, functioning gains, and recovery goals. Such review may help clinicians, patients, families, and other support persons recognize that improvement is taking place or, conversely, identify issues that need further attention.

If more than one quantitative measure is being used, it is important to minimize duplication of questions and avoid overwhelming the patient with an excessive number of scales to complete. Optimal scale properties (e.g., sensitivity, specificity) will differ depending on the desired purpose(s) for using the scale in a given patient. In addition, when choosing among available quantitative measures, psychometric properties (e.g., scale validity, reliability)<sup>1</sup> and the objectives for using the scale (e.g., screening, documenting baseline symptoms, ongoing monitoring) should be considered. Importantly, however, assessments of scale properties are typically conducted cross-sectionally, and therefore less information may be available about longitudinal use.

A number of factors can affect the interpretation of quantitative measures. For example, some scales ask the patient to rate symptoms over several weeks, which can reduce their ability to detect changes in symptoms. This can be particularly problematic in acute care settings, where treatment adjustments and symptom improvement can occur fairly quickly. Other symptom-based quantitative measures focus either on symptom frequency over the observation period or on symptom severity. Although these features often increase or decrease in parallel, that is not invariably the case. Quantitative measures

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<sup>1</sup> Although this discussion of rating scales uses the words “reliability” and “validity” as applying to a scale, as is common in the literature, it should be noted that it is only possible to assess the reliability of test scores (not the test itself) and to assess the validity of interpretations that are made from scale scores (American Educational Research Association, American Psychological Association, and National Council for Measurement in Education 2014).

that ask the patient to consider both symptom frequency and severity can also make the findings difficult to interpret.

It is also possible for rating scales to introduce biases into the assessment process. Factors such as comorbid illnesses, age, language, race, ethnicity, gender, cultural background, literacy, and health literacy are often inadequately addressed during rating scale development. These factors and others can affect patients' interpretation of questions. Thus, the answers to questions and the summative scores on quantitative measures need to be interpreted in the context of the rating scale's properties and the patient's clinical presentation.

The type and extent of quantitative measures used will also be determined by the clinical setting, the time available for evaluation, the urgency of the situation, the availability of validated rating scales in the patient's primary language, and patient age. In adolescents, for example, self-report scales and ratings from parents/guardians and teachers will each provide helpful information (De Los Reyes et al. 2015). In some clinical contexts, such as a planned outpatient assessment, patients may be asked to complete electronic- or paper-based quantitative measures, either prior to the visit or on arrival at the office (Allen et al. 2009; Harding et al. 2011). Between or prior to visits, electronic approaches (e.g., mobile phone applications, clinical registries, patient portal sites in electronic health records) may also facilitate obtaining quantitative measurements (Lewis et al. 2019; Palmier-Claus et al. 2012; Wang et al. 2018). In other clinical contexts, such as acute inpatient settings, electronic modes of data capture may be more challenging. As an alternative, printed versions of scales may be completed by the patient (or a proxy) or administered by the clinician. In emergency settings, use of a quantitative rating scale may need to be postponed until the acute crisis has subsided or until the patient's clinical status permits a detailed examination. Furthermore, some patients may have difficulty completing self-report instruments due to severe symptoms, co-occurring psychiatric conditions, low health literacy, reading difficulties, or cognitive impairment (Harding et al. 2011; Narrow et al. 2013; Valenstein et al. 2009; Zimmerman et al. 2011).

Although recommending a particular measure is outside the scope of this practice guideline, a number of objective, quantitative rating scales are available to monitor symptoms and features of BPD. The 23-item version of the Borderline Symptom List (BSL-23), which is condensed from the 93-item version (Bohus et al. 2007; Central Institute of Mental Health 2020), is a freely available self-report scale that assesses 23 feelings and experiences typically reported by BPD patients (Kleindienst et al. 2020). Individuals are asked to describe the extent to which they experienced a particular item in the past week based on a scale from 0 (not at all) to 4 (very strong) (Kleindienst et al. 2020). The BSL-23, similar to the BSL-93, was found to have high internal consistency, good sensitivity to the effects of treatment, and an ability to discriminate BPD from other psychiatric diagnoses (Bohus et al. 2009). In addition, symptom severity as measured by the BSL-23 appears to correlate with treatment seeking, as well as with the presence of a BPD diagnosis (Kleindienst et al. 2020).

The Borderline Evaluation of Severity Over Time (BEST) is another freely available self-report scale that focuses on the degree to which a symptom interfered with life in the past week and on idealization/devaluation shifts in relationships (Pfohl et al. 2009). In addition, the BEST includes two

anger related items, two abandonment related items, one item for other BPD criteria, and an item for suicidal ideation (Pfohl et al. 2009). It is reported to have high internal consistency and moderate test-retest reliability (Pfohl et al. 2009).

For adolescents, the 11-item Borderline Personality Features Scale for Children includes self-report and parent-report versions (Sharp et al. 2011, 2014; Vanwoerden et al. 2019; Wall et al. 2019).

The self-report version of the Zanarini Rating Scale for Borderline Personality Disorder (ZAN-BPD; Zanarini et al. 2015) is developed from and organized and scored similarly to the interview-based version of the ZAN-BPD (Zanarini et al. 2003). Both versions of the scale require the author's permission for use, are based on the nine items in the DSM-IV criteria for BPD and include anchored ratings on a 5-point scale from 0 (no symptoms) to 4 (severe symptoms). The scores for each item can be summed to yield a total score, or scores can be calculated for four symptom domains, which are affective, cognitive, impulsive, and interpersonal symptoms (Zanarini et al. 1990). Alternatively, the self-report version of the rating scale can be formatted with Yes or No answers to questions for use as a screening measure. Both versions of the ZAN-BPD showed adequate sensitivity to change at 7 to 10 days (Zanarini et al. 2015). In addition, scores of the self-report version of the ZAN-BPD showed high convergent validity with scores based on the interview version of the scale as well as having good internal consistency and excellent same day test-retest reliability (Zanarini et al. 2015).

The Difficulty in Emotional Regulation Scale (DERS; Gratz and Roemer 2004) is another self-report scale that has been used clinically and in research studies of individuals with BPD. It is freely available and consists of 36-items, rated from 1 (almost never) to 5 (almost always), that address six domains: nonacceptance of negative emotions, inability to engage in goal-directed behaviors when distressed, difficulties controlling impulsive behaviors when distressed, limited access to emotion regulation strategies perceived as effective, lack of emotional awareness, and lack of emotional clarity. The psychometric properties of the DERS have been noted to be improved by removing the scale items related to awareness (Hallion et al. 2018; Lee et al. 2016). However, in other respects, the DERS scores generally have good internal consistency and construct validity in adolescents as well as adults (Fowler et al. 2014; Gratz and Roemer 2004; Neumann et al. 2010; Ritschel et al. 2015). In addition, it shows changes with treatment (Gratz et al. 2014; McCauley et al. 2018). There are several shortened versions of the DERS: the DERS-18 (Victor and Klonsky 2016), the DERS-16 (Bjureberg et al. 2016), the DERS-8 (Penner et al. 2022), and the DERS-SF (Kaufman et al. 2016). Results of the shortened versions correlated with findings on the 36-item DERS. Two studies that compared the original 36 item DERS with the DERS-18, DERS-16, and DERS-SF did not find any of these shortened versions to be superior to the others (Hallion et al. 2018; Skutch et al. 2019).

Self-harm, including suicide attempts and non-suicidal self-injury, is common among individuals with BPD (Grilo and Udo 2021; Yen et al. 2021; Zanarini et al. 2008). Although many of the rating scales for BPD symptoms include items related to self-harm, multiple scales exist that provide more detailed information about self-harming behaviors (Latimer et al. 2012; Sansone and Sansone 2010). One example of such a scale is the Deliberate Self-Harm Inventory (DSHI; Gratz 2001), which is a freely available 17-item self-report tool with good test-retest reliability and construct validity (Gratz 2001;



Fliege et al. 2006). In addition to noting which self-harming behaviors are present and their frequency, information from the scale can be transformed into a continuous variable by summing the frequency scores for each item (Gratz and Gunderson 2006). Another scale, the Inventory of Statements About Self-injury, is aimed at assessing the patient's perspective on interpersonal and intrapersonal functions of non-suicidal self-injurious behaviors (Klonsky and Glenn 2009).

The Level of Personality Functioning Scale-Brief Form 2.0 (LPFS-BF) is aimed at assessing personality function more broadly, consistent with the AMPD (Hutsebaut et al. 2016; Weekers et al. 2019). It is freely available and consists of 12 statements that are rated as Very False or Often False, Sometimes or Somewhat False, Sometimes or Somewhat True, or Very True or Often True. Factor analysis suggested that the LPFS-BF evaluates two domains: self-functioning and interpersonal functioning (Weekers et al. 2019). In addition, there was high sensitivity to change at three months of treatment, adding to the evidence that LPFS-BF scores are indicative of personality functioning. (Le Corff et al. 2022; Weekers et al. 2019).

Other self-report rating scales of relevance to individuals with a personality disorder have been reviewed in detail by the International Consortium for Health Outcomes Measurement (ICHOM), a multidisciplinary international working group that conducted a systematic review and subsequent Delphi process to develop a standard set of outcome measures for individuals with personality disorders (Prevolnik Rupel et al. 2021).

Because reductions in symptoms can occur despite significant impairments in quality of life or functioning (Gunderson et al. 2011; Niesten et al. 2016), rating scales that assess these latter domains can also provide helpful information. One example of a scale that can be used to assess quality of life is the WHOQOL-BREF scale (Skevington et al. 2004; The WHOQOL Group 1998; <http://depts.washington.edu/seagol/WHOQOL-BREF>), developed by the World Health Organization. For assessing functioning difficulties due to health and mental health conditions, the DSM-5 includes the 36-item self- and proxy-administered versions of the World Health Organization Disability Schedule 2.0 (WHODAS 2.0; American Psychiatric Association 2013b; Üstün et al. 2010). Other options for assessing functioning include the Social and Occupational Functioning Assessment Scale (SOFAS; American Psychiatric Association 2000) and the Personal and Social Performance scale (Morosini et al. 2000). Several versions of Patient-Reported Outcomes Measurement Information System (PROMIS) scales, which address social roles and functioning, are also available ([www.healthmeasures.net/explore-measurement-systems/promis](http://www.healthmeasures.net/explore-measurement-systems/promis)).

### Statement 3 – Treatment Planning

APA *recommends (1C)* that a patient with borderline personality disorder have a documented, comprehensive, and person-centered treatment plan.

#### *Implementation*

##### *Overview of Treatment Planning*

When treating individuals with BPD, a person-centered treatment plan should be developed, documented in the medical record, and updated at appropriate intervals. Whenever possible,

development and updating of the treatment plan should be done in a collaborative fashion with the patient. When treating an adolescent, parents or other involved caregivers will be crucial to engage when creating a treatment plan. Although patients' relationships with family members can be heterogeneous, many adults will also welcome involvement of family members and others (Cohen et al. 2013; Lamont and Dickens 2021). Input from these individuals can be vital in developing a full picture of the patient (as discussed in Statement 1) as well as in formulating and implementing a person-centered treatment plan. If the patient is also receiving care from another health professional, for BPD or for other conditions, communication with those individuals is essential.

A person-centered treatment plan can be recorded as part of an evaluation note or progress note and does not need to adhere to a defined development process (e.g., face-to-face multidisciplinary team meeting) or format (e.g., time-specified goals and objectives). Depending on the urgency of the initial clinical presentation and the availability of other sources of information, the initial treatment plan may need to be augmented over several visits as more details of history and treatment response are obtained. In adapting treatment to the needs of the individual patient, tailoring of the treatment plan may also be needed on the basis of developmental, sociocultural, or dimensional aspects of personality pathology with an aim of enhancing quality of life or aspects of functioning (e.g., social, academic, occupational). Adjustments to the treatment plan will occur throughout the course of treatment as symptoms or presenting concerns change and as the clinical formulation evolves.

The overarching aims of treatment are 1) to promote and maintain recovery, 2) to maximize quality of life and adaptive functioning, 3) to reduce or eliminate symptoms, including self-injurious and suicidal behaviors, and 4) to address developmental considerations and co-occurring disorders in the context of BPD treatment. To achieve these aims and inform treatment planning, it is crucial to identify the patient's aspirations, goals for treatment, and treatment-related preferences. For patients who have completed a psychiatric advance directive (Kemp et al. 2015; Shields et al. 2014; Wilder et al. 2010), wellness recovery action plan (Copeland 2000), or individualized crisis prevention or safety plan (Stanley and Brown 2012; Stanley et al. 2018), these documents will be important to review with the patient when crafting a person-centered approach to care. When developing an individual treatment plan, the clinician should explain and discuss the range of treatments available for the patient's condition, the modalities that are being recommended, and the associated rationale for having selected them. As part of the discussion, the patient's views of the proposed treatment will be elicited and the plan can be modified, to the extent feasible, to incorporate the patient's views and preferences.

#### Elements of the Treatment Plan

Depending on the clinical circumstances and input from the patient and others, a comprehensive and person-centered treatment plan will typically delineate treatments aimed at improving functioning, reducing symptoms, and addressing core personality features of BPD. If co-occurring psychiatric symptoms or disorders are present, it is important to identify them and incorporate appropriate interventions into the treatment plan. Psychotherapeutic approaches will be at the core of the treatment plan for BPD (see Guideline Statement 5), but medications may also be appropriate to use, typically on a limited basis (see Guideline Statements 6 through 8).

Other elements of the treatment plan will often include the following:

- identifying needs for additional evaluation
  - history or mental status examination
  - physical examination (either by the evaluating clinician or by another health professional)
  - laboratory testing, imaging, electrocardiography (ECG), or other clinical studies (if indicated on the basis of the history, examination, and planned treatments)
- determining the most appropriate treatment setting
- providing psychoeducation about BPD and approaches to treatment
- addressing barriers to adherence
- collaborating with other treating clinicians
- involving family members, other caregivers, and other individuals in the patient's support network
- delineating plans for addressing risks of harm to self or others, if present
- addressing co-occurring disorders, if present
- incorporating goals of treatment related to culturally sensitive care, as well as psychosocial considerations such as school or employment, past or current adversity, or interpersonal, family, or intimate relationships

#### Determining a Treatment Setting

In determining a treatment setting, considerations for individuals with BPD are similar to those for individuals with other diagnoses. Thus, in general, patients should be cared for in the least restrictive setting that is likely to be safe and to allow for effective treatment of BPD and co-occurring conditions. Often, outpatient treatment will be the appropriate setting of care. When a patient requires more monitoring or assistance than is available in routine outpatient care, programs that provide an intermediate level of care (e.g., intensive outpatient programs, partial hospital programs, residential treatment programs) may be indicated. Although evidence is limited, assertive community treatment has occasionally been used for individuals with BPD who have complex health and social service needs, particularly when treatment adherence has been challenging (Grambal et al. 2017; Horvitz-Lennon et al. 2009b).

Indications for hospitalization usually include the patient posing a serious threat of harm to self or others or being unable to care for oneself and needing constant supervision or support as a result. Other possible indications for hospitalization include psychiatric or other medical problems that make outpatient treatment unsafe or ineffective and that warrant initial inpatient stabilization to promote reduction of acute symptoms and permit engagement in treatment. If inpatient care is deemed essential, efforts should be made to hospitalize patients voluntarily. However, if hospitalization is deemed essential but is not accepted voluntarily by the patient, state or jurisdictional requirements for involuntary hospitalization should be followed.

Determination of a treatment setting will also require weighing the pluses and minuses of possible settings to identify the optimal location for care. For example, hospitalization can have benefits in terms

of safety but add to financial burdens, disrupt school, work, or caregiving responsibilities, or be upsetting for patients due to repeated hospitalizations (Comtois and Carmel 2016) or negative experiences of some patients with inpatient care (Stapleton and Wright 2019). In most circumstances, management of the patient on an inpatient psychiatric service in collaboration with consultants of other medical specialties will be optimal. However, individuals with BPD who have other significant health issues may need significant medical or surgical interventions or monitoring that are not typically available on a psychiatric inpatient service. Under such circumstances, the patient will likely be better served on a general hospital unit or in an intensive care setting with input from consultation-liaison psychiatrists and education and supervision of staff to help them engage with the patient in a therapeutic and non-judgmental fashion.

#### [Establishing and Maintaining a Therapeutic Framework and Alliance](#)

The therapeutic relationship is an essential ingredient in treatment of BPD (Bender 2005; Rudge et al. 2020) and for mental health treatment in general (Baier et al. 2020; Frank and Frank 1993; Oldham 2022b; Stubbe 2018). Because patients with BPD may have difficulty developing and sustaining trusting relationships, establishing and strengthening the therapeutic alliance will generally be a focus of treatment from the initial session (Culina et al. 2023). Although the underpinnings of the therapeutic alliance vary, clinicians are expected to offer understanding, responsiveness, explanations for treatment interventions, undistracted attention, and respectful, validating, and compassionate attitudes, with judicious feedback to patients that can help them develop self-efficacy and attain their goals. In addition to interactions with the treating clinician or treatment team, the therapeutic alliance can also be affected by the patient's prior experiences, including those related to biases and health disparities (e.g., related to race, ethnicity, sexual orientation, or gender) (Maharaj et al. 2021; Spengler et al. 2016; Sue et al. 2007). At the outset of treatment, it is important to establish a clear and explicit treatment framework with which the patient agrees (Sledge et al. 2014). While this process is generally applicable to the treatment of all patients, regardless of diagnosis, such an agreement is particularly important for patients with BPD and can serve as a model for healthy boundaries in other aspects of the patient's life. As part of this treatment framework, patients and clinicians should establish agreements about goals of treatment sessions (e.g., symptom reduction, personal growth, improvement in functioning), ways to facilitate these goals (e.g., reporting on such issues as conflicts, dysfunction, and impending life changes; completing homework between sessions; development of an individualized safety plan) and what role each is expected to perform to achieve these goals. Although some therapeutic approaches incorporate specific criteria that would lead treatment to be discontinued, it is always important to emphasize these aspects of the treatment framework that will help contribute to treatment success. In addition, it is essential for patients and clinicians to work toward establishing agreements about 1) when, where, and with what frequency sessions will be held; 2) notification of planned or urgent session cancellations or delays in keeping appointments; 3) the fee, billing, and payment schedule; 3) clarification of the clinician's after-hours availability; and 4) a plan for crisis management, which may include a coordinated plan for patients to have intersession access to the treatment team. Furthermore, it is important to review expectations if emergency care is needed. Mechanisms for emergency department staff to reach and communicate with the treatment team are equally important when a patient is in crisis.

To adhere to a framework for successful treatment, clinicians will often need to communicate with patients about realistic limits while simultaneously addressing patient concerns. In communicating limits, the clinician should recognize that an excessive focus on limits may overshadow treatment goals and compromise the therapeutic alliance. Rather, the focus should be on preventing harm to the patient, maintaining appropriate boundaries to facilitate treatment, and fostering open communication about the patient's experience in treatment. For example, clinicians may need to reiterate aspects related to payment, times that they can be available to the patient, clinical coverage during vacations, or plans for dealing with phone calls or crises (Epstein 1994; Gabbard and Wilkinson 2000; Skodol and Oldham 2021). Clinicians may also need to address specific patient behaviors that would be disruptive to the therapeutic relationship or that would suggest a need for treatment plan revisions. For example, patients may be reluctant to disclose self-harming behaviors, yet recognizing that these behaviors are occurring could lead the clinician to a greater understanding of the patient's internal experiences. In addition, patients, family members, or others involved in the patient's care may need to raise concerns about factors that could rupture the therapeutic relationship (e.g., sudden changes in the clinician's schedule; perceived biases in the clinician's attitude or interactions; negative experiences with the clinician, other treatment team members, administrative staff members, or other group therapy participants). In discussing such concerns, the clinician should remain non-judgmental while gaining an understanding of the patient's experience.

The intensity of the patient's emotional experience and the behaviors that are part of BPD can also evoke a variety of emotional reactions (i.e., countertransference) in clinicians that range from warmth and empathy to desires to "rescue" the patient to negative feelings (e.g., frustration, anger) (Bhola and Mehrotra 2021). If not recognized by the clinician, such emotional reactions can impact clinical decision-making in ways that are not in the best interest of the patient. Team consultation and supervision are important avenues for understanding these emotional responses and perspectives of different clinicians so that treatment is not adversely affected. If treatment is discontinued, whether by the patient or the clinician, attention should be given to its timing and to transfer of care (AMA Code of Medical Ethics 2023a). If the treatment termination process is unusually difficult or complex, obtaining a consultation should be considered.

Even when the framework of treatment has been developed and agreed to at the start of treatment, situations can arise in which the boundaries of the treatment framework are blurred or crossed (Bender 2005; Gutheil 2005). Certain situations (e.g., practicing in a small community, rural area, or military setting) may complicate the task of maintaining treatment boundaries (Sederer et al. 1998). The advent of the Internet and social media has introduced additional challenges (Gabbard et al. 2011). Nevertheless, it is always the clinician's responsibility to monitor and sustain the treatment framework. Furthermore, clinicians should be proactive in exploring the meaning of any boundary crossing—whether originating from their own behavior or that of the patient—and restate their expectations about the treatment boundaries and their rationale (Bender 2005; Gutheil 2005). Clinicians should also be alert to their own feelings toward the patient and any deviations from their usual way of practicing that may signal a risk of boundary violations (e.g., appointments at unusual hours, longer-than-usual appointments, doing special favors for the patient, developing a personal friendship outside of the

professional situation) (Gutheil 2005). In such circumstances, consultation, personal psychotherapy, or both may be warranted. Sexual interactions between a clinician and a patient are always unethical and, in most jurisdictions, a reportable event that can affect continued licensure (Gutheil 2005; MacIntyre and Appel 2020). If this type of boundary violation occurs, the clinician should immediately refer the patient to another clinician.

### Strategies to Promote Adherence

Adherence with treatment is a crucial aspect of achieving therapeutic benefit, yet clinical studies of BPD typically have significant drop-out rates (Barnicot et al. 2011; Iliakis et al. 2021). Thus, strategies to promote adherence are always important to consider when developing a patient-centered treatment plan. Adherence will generally be aided by obtaining patient input, engaging in shared decision-making as part of treatment planning, and developing a collaborative therapeutic alliance (Barnicot et al. 2022; de Freixo Ferreira et al. 2023). In youth, one study suggests that youth-oriented case management and psychiatric care focused on BPD is associated with better adherence and treatment retention than general youth-oriented care models (Chanen et al. 2022). Some potential factors that can influence adherence may become evident during the initial evaluation or early sessions. These include difficulties in prior therapeutic relationships, ineffectiveness of prior treatment, viewing treatment as unnecessary, perceptions of stigma about needing treatment (including self-stigma), prior difficulties with adherence, cultural or family beliefs about illness or treatment, lack of support from significant others for treatment, or the presence of co-occurring conditions (e.g., depression; alcohol, cannabis, or other SUDs). Other common issues with adherence to treatment include financial barriers (e.g., cost, lack of insurance or under-insurance), difficulties scheduling visits around work or school schedules, limited geographic availability or accessibility of services, or issues with transportation or with childcare. When medications are a part of the treatment plan, many of the same elements apply (e.g., cost, lack of perceived need for treatment, concerns about prior treatment experiences or stigma). In addition, patients may have concerns about side effects (e.g., weight gain, sexual dysfunction) or difficulty with managing complex regimens (e.g., due to frequency of doses, number of medications) (Anderson et al. 2020; Kardas et al. 2013; Nieuwlaat et al. 2014; Peh et al. 2021). These potential contributors to nonadherence can be explored proactively or reassessed if adherence difficulties develop. Addressing these barriers as part of the treatment plan will require active collaboration and problem-solving between the clinician and patient, often with input from the patient's family and others involved in the patient's life. With adolescents, involvement of parents, family members, and other caregivers is critical.

### Using Peer-Support Programs to Enhance Care

Peer-support programs have been used in substance use disorder treatment programs (Substance Abuse and Mental Health Services Administration 2022) as well as in mental health treatment programs (Høgh Egmo et al. 2023; Mirbahaeddin and Chreim 2022), more broadly. Although research on peer support programs has been limited, available evidence suggests that they may have small positive effects on anxiety and personal recovery (Høgh Egmo et al. 2023). Peer support can also be used to complement, but not replace, other treatment approaches in various settings and formats (e.g., individual, group, in-person, on-line) (Emotions Matter 2023b; Høgh Egmo et al. 2023; Mirbahaeddin

and Chreim 2022; Substance Abuse and Mental Health Services Administration 2022). In patients with BPD, peer support may help individuals feel less isolated, more understood, provide hope, and assist in developing coping skills from the perspective of someone with lived experience (Barr et al. 2022a, 2022b). When peer support is used as part of the treatment plan, it is important to have a specific framework or structure in place (e.g., as with the peer support groups provided by Emotions Matter [2023b]). If peer support services are integrated into hospital-based or outpatient-based treatment programs, other implementation issues will need to be considered to optimize benefits and avoid potential harms for the patient and for the peer support worker (e.g., role definitions and boundaries, supervision, privacy of patient health records, relationships with team-members; Mirbahaeddin and Chreim 2022).

### Coordinating the Treatment Effort

Treatment of BPD can be provided by a single clinician, performing multiple tasks, or by more than one clinician, each performing separate treatment tasks. Treatment by multiple clinicians has potential advantages but can contribute to fragmentation of care. Consequently, when a team-based approach to treatment is used, it is essential that ongoing coordination of the overall treatment plan is assured by clear role definitions, plans for management of crises, and regular communication among the clinicians and the patient. Often, family members and other caregivers will also be involved in care coordination, and this is particularly crucial in the treatment of adolescents. Communication and coordination of care may also be needed with primary care or specialty care clinicians who are addressing the patient's physical health needs.

When treatment is provided by multiple clinicians, divisiveness or polarization among treatment team members can be associated with the tendency for idealization and devaluation of others (i.e., "splitting") as a part of BPD. It is the responsibility of the treatment team to manage such issues if they occur, recognize the heightened need for intentional communication, and enhance coordination among involved clinicians to assure that therapeutic decision-making is not compromised. For this reason, many treatments for BPD are explicit in defining roles and relationships among treatment team members.

### Addressing Risks for Suicidal and Aggressive Behavior

#### General Aspects of Risk Assessment

Identifying risk factors and estimating risks for suicidal and aggressive behaviors are essential parts of psychiatric evaluation (American Psychiatric Association 2016a and as described in detail in the Implementation section of Statement 1). Despite identification of these risk factors, it is not possible to predict whether an individual patient will engage in aggressive behaviors or attempt or die by suicide. However, when an increased risk for such behaviors is present, it is important that the treatment plan identifies the optimal setting of care and implements approaches to target and reduce modifiable risk factors. Although demographic and historical risk factors are static, potentially modifiable risk factors may include poor adherence, co-occurring symptoms (e.g., depression, hopelessness, hostility, impulsivity, sleep disturbance), or co-occurring diagnoses (e.g., depression, alcohol use disorder [AUD], other SUDs, physical health conditions). Life events that may increase risk in an individual patient may include traumatic experiences, disrupted relationships, perceived failures at school or work, or discrimination experienced in relation to race, ethnicity, or gender. Risk may be reduced by increased



monitoring or more intensive services during periods of increased risk (e.g., with significant psychosocial crises, during incarceration, subsequent to hospital discharge). With adolescents, and often, with patients of other ages, involvement of family members or other caregivers can be helpful in strengthening social support networks and providing collateral information that is relevant to risk assessment (Mammen et al. 2020).

#### Risk for Suicide and Suicidal Behaviors

Although suicidal ideation does not occur in all patients with BPD (Zimmerman and Becker 2023), many individuals with BPD will experience suicidal ideation at some point in their lifetime. It is estimated that self-injurious behavior occurs in over 90% of those with BPD, with suicide attempts in approximately 75% and suicide death in 3%-10% (Black et al. 2004; Cipriano et al. 2017; Goodman et al. 2017; Grilo and Udo 2021; Kjær et al. 2020; Leichsenring et al. 2011; Links et al. 2013; Machado et al. 2022; Paris 2019; Temes et al. 2019; Yen et al. 2021; Zanarini et al. 2008). Managing suicide risk in individuals with BPD can be challenging for a number of reasons. For the patient, suicidal thoughts are associated with distressing internal experiences that may include feelings of hopelessness, failure, loss of control, or harsh self-criticism (Berg et al. 2017, 2020; Gaily-Luoma et al. 2022; Schechter et al. 2019). In addition, because patients with BPD may have difficulty forming stable interpersonal relationships, it can be difficult for them to work collaboratively in treatment to reduce their risk of serious self-harm or suicide. Furthermore, many patients with BPD have ongoing risk factors for suicide (e.g., prior suicide attempts, chronic thoughts of suicide, frequent episodes of non-suicidal self-injury), which makes it difficult to discern when a patient is at imminent risk of making a serious suicide attempt. Even with careful attention to suicide risk, it is often difficult to predict serious self-harm or suicide, because this behavior can occur impulsively and without warning. Because of the heightened risk of suicide attempts and suicide death in individuals with BPD, it is important for patients to be monitored for suicide risk, for suicide risk assessments to be documented, for individualized safety plans to be developed (Nuij et al. 2021; Stanley and Brown 2012; Stanley et al. 2018), and for treatment plans to be adjusted or reformulated as clinically necessary.

APA's Practice Guidelines for the Psychiatric Evaluation of Adults 3<sup>rd</sup> Edition (American Psychiatric Association 2016a) include detailed information on specific elements to assess in making a determination about suicide risk (see Table 2). Structured approaches to assessing suicide risk can also be helpful in asking about and documenting suicide related risk information in a consistent fashion. Examples of such approaches include the Suicide Assessment Five-Step Evaluation and Treatment (SAFE-T) framework (Substance Abuse and Mental Health Services Administration 2009) and the Assessment of Suicide and Risk Inventory (ASARI; Black 2013; Health Standards Organization 2023).

If suicidal ideas, plans, or intent are reported, these should be addressed with the patient. Collaborating with the patient in developing an individualized crisis prevention or safety plan is an essential component of this process (Nuij et al. 2021; Stanley and Brown 2012; Stanley et al. 2018). In the absence of acute factors increasing suicide risk, chronic aspects of risk can typically be addressed in the context of therapy. However, the clinician should also be mindful of situations such as feelings of rejection, fears of abandonment, changes in treating clinicians, or conflicts in interpersonal relationships that may have precipitated suicidal ideas or behaviors in an individual patient in the past. When co-occurring disorders



are present that may increase suicide risk (e.g., depressive episodes, alcohol or other SUDs), these should be addressed as part of the treatment plan, if not already being treated.

If significant acute suicide risk is present, actions such as hospitalization may be needed to provide more intensive observation and treatment and reduce the risk of serious self-harm. Referral to a more intensive level of care may also be needed if self-injurious behaviors are frequent. If patients with high levels of suicide risk do not appear to be responding to treatment, consultation with a colleague can be useful.

#### Risk for Aggressive Behavior

Anger and impulsivity are other aspects of emotional dysregulation that are common in individuals with BPD and can be directed inwardly or at others, including the clinician. Anger is particularly likely to occur when there is a disruption in the patient's relationships or when the patient feels frustrated, abandoned, betrayed, or seriously misunderstood. Thus, it can be helpful to gain a better understanding of the patient's internal experience and its association with anger, while emphasizing the need to maintain boundaries of acceptable behavior for purposes of safety. As with suicide risk, it is important for patients to be monitored for risks of aggression, for such risk assessments to be documented, and for treatment plans to be adjusted or reformulated as clinically necessary. However, even with close monitoring and attention to anger, impulsivity, and aggression risk, it is difficult to predict their occurrence. In addition, a complicating factor is that the patient's anger or behavior may produce anger in the therapist, which has the potential to adversely affect clinical judgment.

APA's Practice Guidelines for the Psychiatric Evaluation of Adults 3<sup>rd</sup> Edition (American Psychiatric Association 2016a) include detailed information on specific elements to assess in making a determination about the risk of aggressive behaviors (see Table 2). In terms of BPD, patients who also have antisocial personality traits or antisocial personality disorder may be at further risk of aggression to others and severe antisocial features may limit the viability of psychotherapy. Aggression may also be more likely when an SUD is present (Zanarini et al. 2017), when anger is intense (Neukel et al. 2022), when impulsivity and intense anger occur in the presence of identity disturbance (Harford et al. 2019), or when an individual has experienced verbal, emotional, physical, or sexual abuse during adulthood (Zanarini et al. 2017). Contacts with law enforcement or the criminal justice system can occur in individuals with BPD (Epshteyn and Mahmoud 2021; Nakic et al. 2022; Wetterborg et al. 2015) and may be more common in those who experience anger as a prominent symptom (Kolla et al. 2017; McGonigal and Dixon-Gordon 2020). In addition, men with BPD may be more likely to present with externalizing symptoms, such as anger, than women with BPD (Qian et al. 2022).

If the risk of aggression is substantial or if violence appears to be imminent, a higher level of care or hospitalization may be needed to provide more intensive evaluation and observation, to help the patient regain control, and to adjust the treatment plan to reduce risk. Whenever an individual has aggressive or homicidal ideas or behaviors, it is important to identify any intended targets of aggression. If a specific target is identified, the clinician will need to use clinical judgment in deciding whether the patient requires a more supervised setting of care (to provide protection for the identified target and more intensive treatment for the patient) or whether the identified target should be warned of the

potential for harm, or both. There is also considerable variability by state on the case law and statutes that address the Tarasoff duty to protect (Soulier et al. 2010), and the clinician will want to become familiar with the requirements of the local jurisdiction.

#### Monitoring and Reassessing the Patient's Clinical Status and Treatment Plan

As treatment proceeds, iterative reevaluation of treatment effectiveness will be essential. Although discussions with the patient, family members, and others will typically occur as part of the initial assessment (see Statement 1), additional input is helpful as treatment proceeds and the treatment plan is updated. Discussion with parents or other involved caregivers is particularly important when treating adolescents and emerging adults.

Often the course of treatment is uneven, and setbacks may occur (e.g., at times of heightened stress). Such setbacks do not necessarily indicate that the treatment is ineffective. Rather, therapeutic efforts may facilitate coping strategies to address such situational precipitants. Nonetheless, it is reasonable to expect an overall trend towards improvement.

Features of BPD are of a heterogeneous nature. Some patients, for example, display prominent affective instability, whereas others exhibit marked impulsivity or antisocial traits. Because of this heterogeneity, and because of each patient's unique history, the treatment plan needs to be flexible, adapted to the needs of the individual patient. Flexibility is also needed to respond to the changing characteristics of patients over time (e.g., at one point, the treatment focus may be on safety, whereas at another, it may be on improving relationships and functioning at work). Similarly, the clinician may need to use different treatment modalities or refer the patient for additional treatments (e.g., behavioral, supportive, or psychodynamic psychotherapy) at different times during the treatment or if prior treatments have not been associated with a sufficient clinical response.

If improvement is not occurring or if there are significant changes in presenting issues or symptoms, the diagnosis and treatment plan should be reassessed and a change in the approach to treatment should be considered. When changes to the treatment plan are made, attention should be paid to careful and adequate documentation, including the decision-making process, communication with other clinicians, and the rationale for the treatment change including aspects related to risk of suicidal or aggressive behaviors. Consultation with a colleague can also be useful when the patient is not improving. It should also be considered for unusually high-risk patients (e.g., when suicide risk is very high) or when it is unclear what the best treatment approach might be. When a consultation has occurred, it is important to document the recommendations, whether the recommendations were followed or not, and, if the clinician made a different treatment decision, why the recommendations were not followed.

#### Addressing Co-occurring Psychiatric Disorders

Patients with BPD often have other co-occurring psychiatric disorders, such as mood disorders, PTSD, anxiety disorders, eating disorders, ADHD, SUDs, and other personality disorders (Choi-Kain et al. 2022; Friborg et al. 2014; Geluk Rouwhorst et al. 2022; Grant et al. 2016; Gunderson et al. 2014; Keuroghlian et al. 2015; Leichsenring et al. 2011; Lenzenweger et al. 2007; McDermid et al. 2015; McGlashan et al. 2000; Miller et al. 2022; Momen et al. 2022; Santo et al. 2022; Tate et al. 2022; Trull et al. 2018; Zanarini

et al. 2004a, 2010, 2019; Zimmerman et al. 2017). When the presence of co-occurring disorders has been studied in adolescents with BPD, similar increases in the frequency of internalizing and externalizing disorders have been found (Fonagy et al. 2015; Ha et al. 2014; Sharp and Fonagy 2015). These disorders can complicate the clinical picture and need to be addressed in treatment. Furthermore, when a co-occurring disorder is present, the clinical presentation may be more severe and symptom remission is often more difficult to achieve in the co-occurring disorder (Ceresa et al. 2021; Geluk Rouwhorst et al. 2022; Gunderson et al. 2014; Keuroghlian et al. 2015).

#### Mood Disorders

BPD is common among patients with bipolar disorder, affecting about 1 in 5 bipolar patients overall and an even greater proportion of those with bipolar II disorder (Fornaro et al. 2016). In patients with MDD, estimates suggest that about 15% have BPD (Friborg et al. 2014). Conversely, almost all individuals with BPD will have at least one episode of MDD in their lifetime (Gunderson et al. 2008) and depressive episodes are often recurrent and/or persistent (Gunderson et al. 2008; Skodol et al. 2011).

In patients with BPD, it can be challenging to distinguish mood episodes of bipolar disorder or MDD from mood related symptoms and affective instability due to BPD. Prior to considering specific treatments for symptoms of depression or affective instability, it is important to establish whether major depression or bipolar disorder is present. This will usually require a detailed longitudinal history of symptoms, treatments, and treatment responses, as well as specific information about associated symptoms and patterns of symptoms, family history of mood disorders, and history from collateral informants. For example, individuals can experience suicidal ideas and hopelessness as elements of depressive episodes or BPD; however, neurovegetative symptoms are more commonly seen with MDD whereas fears of abandonment, feelings of emptiness, self-destructive behaviors, and non-suicidal self-injury are more consistent with a diagnosis of BPD (American Psychiatric Association 2022a). The presence of psychotic symptoms and a family history of bipolar disorder are also more likely in individuals with bipolar disorder as compared to those with BPD alone (Durdurak et al. 2022). When compared to individuals with mood disorders alone, individuals with BPD and co-occurring mood disorder are more likely to have atypical features of depression (Gremaud-Heitz et al. 2014), aggressive features (Tong et al. 2021), and suicidal behaviors (Söderholm et al. 2020).

If concomitant bipolar disorder is present in a patient with BPD, there is limited evidence on the optimal approach to treatment (Frankenburg and Zanarini 2002; Gartlehner et al. 2021). Although lamotrigine appears to have efficacy in patients with bipolar depressive episodes (Yildiz et al. 2023), a large randomized controlled trial (RCT) in patients with BPD alone showed no significant clinical effect on BPD (Crawford et al. 2018). Information on treatment with valproic acid or lithium in individuals with bipolar disorder and BPD is even more limited. Lithium treatment is effective in the treatment and prevention of manic episodes (Fountoulakis et al. 2022) and is associated with a decrease in long-term risk of suicide in bipolar disorder patients in most (Chen et al. 2023; Wilkinson et al. 2023), but not all (Wortzel et al. 2023) studies. Nevertheless, its narrow therapeutic index and toxicity in overdose are important to keep in mind (Barroilhet and Ghaemi 2020; Wortzel et al. 2023) for patients with BPD and bipolar disorder who have significant impulsivity and risk for suicide.

When MDD and BPD co-occur, some data suggest that patients may be less likely to respond to treatments for depression than patients with MDD alone. Nevertheless, many such patients will respond to evidence-based treatments for MDD (Ceresa et al. 2021), and the initial choice of an antidepressant should follow guideline-based recommendations (American Psychiatric Association 2010; Department of Veterans Affairs/Department of Defense 2022). In addition, treatment of BPD may improve the chance of depression response (Ceresa et al. 2021). Several small studies of selective serotonin reuptake inhibitors (SSRIs) showed benefits in patients with MDD and BPD (Ceresa et al. 2021). Because of their frequent use in the treatment of MDD alone, SSRIs tend to be used most often in patients with co-occurring MDD and BPD (Ceresa et al. 2021; Pascual et al. 2023). Serotonin and norepinephrine reuptake inhibitors (SNRIs) have not been well-studied in patients with BPD and MDD. Several small studies in the older literature suggested that monoamine oxidase inhibitors (MAOIs) may be more beneficial than tricyclic antidepressants (TCAs) in individuals with BPD (Cowdry and Gardner 1988; Parsons et al. 1989), particularly if atypical depressive symptoms were present. Although MAOIs can be an option in individuals with MDD whose depressive symptoms have not responded to other antidepressive treatments (Van den Eynde et al. 2022a), they are rarely used in patients with MDD and BPD. If considered, factors such as impulsivity, concomitant substance use, and suicidal behaviors need to be weighed carefully because of potential for drug-drug and drug-diet interactions (Van den Eynde et al. 2022a, 2022b) with MAOI treatment.

Because patients with BPD can have significant suicide risk and repeated suicidal attempts or hospitalizations for suicidal ideation, they are sometimes referred for ECT on this basis. As noted above, before considering treatment such as ECT, it is important to establish whether mood related symptoms including suicide related risks are related to a concomitant mood disorder rather than attributable to BPD. As with other antidepressant treatments in individuals with BPD, most of the available evidence suggests that patients with concomitant BPD and mood disorder can respond to ECT (Feske et al. 2004; Hein et al. 2022a, 2022b; Kaster et al. 2018; Rasmussen 2015). Despite this, when BPD and MDD co-occur, response may be slower, remission and response rates may be less robust, and relapse may be more frequent after ECT is stopped than in depressed patients without BPD (Feske et al. 2004; Hein et al. 2022a, 2022b; Kaster et al. 2018; Rasmussen 2015). These factors should be weighed along with the other potential benefits and risks of ECT before making specific treatment recommendations. Although data on benefits of TMS are more limited than data on ECT in patients with concomitant MDD and BPD, there is less potential risk, particularly in terms of cognitive side effects (Cailhol et al. 2014; Chiappini et al. 2022; Feffer et al. 2022; Konstantinou et al. 2021; Reyes-López et al. 2018). In addition, one study suggests that response to TMS in BPD patients is comparable to response in patients without BPD (Ward et al. 2021).

Even less is known about the use of ketamine to treat depressive episodes in patients with BPD who have co-occurring bipolar disorder or MDD. In patients with BPD, a small RCT of a single infusion of ketamine as compared to midazolam showed no effects on the primary outcome of suicidal ideation or secondary outcomes of anxiety, depression, or BPD symptoms although socio-occupational functioning was better with ketamine at 14 days (Fineberg et al. 2023). In terms of potential adverse effects, one case report suggests that intravenous ketamine might be associated with worsening symptoms of BPD

(Vanicek et al. 2022). The occurrence of dissociative symptoms in other studies of ketamine treatment (Fineberg et al. 2023; McIntyre et al. 2021; Rhee et al. 2022; Williamson et al. 2023) also suggests that caution and careful monitoring should occur if ketamine is used to treat depressive episodes in an individual with BPD.

#### Anxiety Disorders

Anxiety disorders, like mood disorders, are common in individuals with BPD (Ansell et al. 2011; Leichsenring et al. 2023; McGlashan et al. 2000; Qadeer Shah et al. 2023; Zanarini et al. 1998, 2004a; Zimmerman and Mattia 1999) and may represent an initial reason for patient assessment (Zimmerman and Becker 2023). Reported rates of anxiety disorders vary with the sampling method and the setting of care in clinical samples, however, rates of panic disorder and social phobia are high in individuals with BPD, occurring in one-fifth to almost one-half of some samples (McGlashan et al. 2000; Qadeer Shah et al. 2023; Zanarini et al. 1998, 2004a; Zimmerman and Mattia 1999). Simple phobias are reported in about one-quarter of individuals with BPD whereas generalized anxiety disorder and obsessive-compulsive disorder (OCD) occur in one-sixth to one-fifth of the samples (McGlashan et al. 2000; Qadeer Shah et al. 2023; Zanarini et al. 1998, 2004a; Zimmerman and Mattia 1999). Information on the course of co-occurring anxiety disorders in BPD is limited as many of the available studies have enrolled inpatients. Nevertheless, when assessed longitudinally, the prevalence of anxiety disorders in patients with BPD appears to fluctuate, as symptoms remit and recur, and as some individuals develop a new anxiety disorder diagnosis (Silverman et al. 2012; Zanarini et al. 2004a). In addition, the overall proportion of anxiety diagnoses appears to decrease somewhat with time though remaining elevated relative to individuals with other personality disorders (Silverman et al. 2012; Zanarini et al. 2004a) or rates of anxiety disorders in general community samples (Kessler et al. 1994).

In terms of treatment of anxiety disorders, few studies have assessed specific treatment approaches in patients with co-occurring BPD (Harned and Valenstein 2013; Pascual et al. 2023). Consequently, treatment approaches would typically include addition of anxiety-focused elements to psychotherapy or use of antidepressants, if appropriate for treatment of the co-occurring anxiety disorder. Use of benzodiazepines is not generally recommended because of the potential for greater impulsivity or disinhibition as well as the potential for misuse or development of dependence (Leichsenring et al. 2023; Lieslehto et al. 2023; Pascual et al. 2023).

#### Eating Disorders

The co-occurrence of BPD and eating disorders varies with the specific eating disorder and its subtype. Rates of BPD are greatest in bulimia nervosa and the binge-purge subtype of anorexia nervosa as compared to the restrictive subtype (Reas et al. 2013; Sansone et al. 2005; Skodol et al. 1993).

Among clinical samples of patients with BPD, eating disorder diagnoses were frequent, with greater rates in inpatient than outpatient samples (Chen et al. 2009; Martinussen et al. 2017; Zanarini et al. 2021). Symptoms related to eating are also common in patients with BPD even when full criteria for an eating disorder are not met (Marino and Zanarini 2001). Notably, most studies on BPD and eating disorder co-occurrence have been done in women with either anorexia nervosa or bulimia nervosa; limited information is available on individuals of other genders or those with binge-eating disorder.

As in BPD, in adults, an evidence-based psychotherapy is the primary treatment for anorexia nervosa or for binge-eating disorder, with psychotherapy alone or in combination with serotonin reuptake inhibitor (e.g., fluoxetine) recommended for bulimia nervosa (American Psychiatric Association 2023). In adolescents and emerging adults who have an involved caregiver, an eating disorder-focused family-based treatment is recommended for anorexia nervosa and suggested for bulimia nervosa (American Psychiatric Association 2023). Consequently, for individuals with a co-occurring diagnosis of BPD and an eating disorder, psychotherapy may be able to address both conditions simultaneously. In other circumstances, with medical instability or significant nutritional compromise, stabilization of the eating disorder may be needed (American Psychiatric Association 2023) prior to initiating treatment for BPD.

#### Substance Use Disorders

SUDs, including AUD, are also common in patients with BPD (Carpenter et al. 2016; Grant et al. 2016; Santo et al. 2022; Trull et al. 2018). Patients with BPD and co-occurring SUDs often have poorer outcomes than those with BPD alone, and risks are greater for morbidity and mortality related to injuries or suicidal behaviors (Doyle et al. 2016; Heath et al. 2018a; Kjær et al. 2020). Substance use may heighten risks of being victimized (Seid et al. 2022; Victor and Hedden-Clayton 2023) and can also increase impulsivity and lower the threshold for acting on self-injurious behaviors. Consequently, inquiring about substance use is an important aspect of history taking. It is also helpful to provide patients with education on the risks of substance use in the context of BPD. When substance use is present, motivational interviewing and brief interventions can be used as initial steps. For individuals with an SUD, concomitant treatment or referral for treatment is essential. Depending on the severity of the SUD, stabilization may be needed before initiating BPD treatment, and inpatient treatment may be needed for withdrawal management and/or more intensive interventions. For some patients, participation in a community-based peer support group such as a 12-step program can be helpful, although there is a paucity of research on these modalities (Ferri et al. 2006). Nevertheless, the focus and structure of groups can vary considerably, and, in some instances, emotional distress or harm can occur in relation to issues such as boundary management. For these reasons, community-based peer support programs cannot substitute for formal medical treatment in the management of SUDs.

Evidence-based pharmacotherapy (e.g., opioid agonist or antagonist treatment for opioid use disorder, acamprosate or naltrexone for AUD) should also be recommended when appropriate to the patient's clinical condition. In addition to the benefits of oral and LAI naltrexone in AUD (Bahji et al. 2022; Kedia et al. 2022; Murphy et al. 2022), oral naltrexone has been noted to reduce self-injurious behavior in open label studies (Roth et al. 1996), retrospective analyses (Timäus et al. 2021), and case reports (Griengl et al. 2001; McGee 1997). However, clinical observations suggest that, in some patients treated with naltrexone, self-injurious behavior may escalate in frequency or severity rather than decline. If patients are receiving medication treatment through an SUD treatment program or primary care clinician, ongoing communication and coordination of care is important as described in the section above on Coordinating the Treatment Effort.

#### Posttraumatic Stress Disorder

In comparison with the general population or comparison groups with other psychiatric disorders, individuals with BPD have higher rates of having experienced childhood adversity or traumatic

experiences as an adult (de Aquino Ferreira et al. 2018; Hailes et al. 2019; Porter et al. 2020; Solmi et al. 2021). Individuals may also have experienced trauma related to discrimination such as that related to race, ethnicity, sexual orientation, or gender (Maharaj et al. 2021; Spengler et al. 2016; Sue et al. 2007). Among individuals with BPD, there is an increased incidence of PTSD (Scheiderer et al. 2015) and concomitant symptoms of PTSD can occur without meeting full criteria for a diagnosis of PTSD (American Psychiatric Association 2022a). Notably, individuals with both disorders have greater rates of exposure to multiple and interpersonal trauma than individuals with either disorder alone (Jowett et al. 2020a). Although there can be some overlap of BPD with the features of complex PTSD, these two conditions appear to be conceptually and clinically distinct (Ford and Courtois 2021; Giourou et al. 2018; Jowett et al. 2020b; Maercker et al. 2022).

In terms of treatment for PTSD, individuals who have concomitant BPD will typically require a phased approach to treatment in which exposure-based treatment is begun only after solidifying the therapeutic alliance and stabilizing BPD symptoms, including significant suicide risk. Although meta-analyses have not shown an increase in adverse effects when exposure-based treatments are used to treat PTSD in patients with BPD, the available studies have typically used a phased approach and excluded patients with significant suicide risk (Slotema et al. 2020; Zeifman et al. 2021). DBT has been used to treat PTSD with the results of an RCT showing benefit with DBT as compared to a wait-list control group (Bohus et al. 2013). Notably, in the subgroup of patients with co-occurring PTSD and BPD, the reduction in PTSD symptoms was comparable to that seen in patients with PTSD only (Bohus et al. 2013), whereas BPD symptoms were less responsive to DBT when PTSD was present as compared to BPD alone (Barnicot and Priebe 2013). In comparative effectiveness studies in patients with PTSD, comparable outcomes were found with DBT and cognitive processing therapy (CPT) (Bohus et al. 2020). Another comparison of DBT and GPM for PTSD showed that both treatments were associated with comparable improvement in PTSD symptoms, but patients with co-occurring PTSD began and ended with more symptoms than those with BPD alone (Boritz et al. 2016). Eye movement desensitization and reprocessing (EMDR) is another treatment approach that has been studied in PTSD (Cuijpers et al. 2020; Hudays et al. 2022; Mavranouzouli et al. 2020) and suggested or recommended as a PTSD treatment in a number of practice guidelines (Courtois et al. 2017; Martin et al. 2021; Department of Veterans Affairs/Department of Defense 2023). Most research suggests that the effects of EMDR are comparable to CBT; however, many of these studies have significant biases. When meta-analyses have focused on studies with a low risk of bias, benefits of EMDR appear less robust (Cuijpers et al. 2020; Hudays et al. 2022; Mavranouzouli et al. 2020). In patients with BPD and PTSD, only pilot data are available, which is insufficient to support EMDR use in this context (Wilhelmus et al. 2023).

Some individuals with BPD may experience auditory hallucinations, dissociative symptoms, or both; each of these symptoms may be more common in individuals with BPD who have experienced trauma. When auditory hallucinations are present, they are often related to stress. In contrast to hallucinations in schizophrenia, individuals with BPD who experience hallucinations will not typically have formal thought disorder, flat or blunted affect, or negative symptoms (Beatson et al. 2019; Niemantsverdriet et al. 2017; Slotema et al. 2018). Although psychotic symptoms will be mild and transient in most patients with BPD,



the presence of more severe or persistent psychosis should prompt additional evaluation for a concomitant psychotic disorder such as schizophrenia.

Dissociative symptoms, including depersonalization and derealization, can be transient but can also be severe or frequent and interfere with treatment and with psychosocial functioning (Bohus et al. 2021; Krause-Utz 2022; Shah et al. 2020). Dissociative identity disorder can also co-occur with BPD (Al-Shamali et al. 2022; Brand and Lanius 2014; Scalabrini et al. 2017). In a transdiagnostic sample, dissociative symptoms were associated with an increased risk of self-harm and suicide attempts (Sommer et al. 2021), whereas in studies of DBT, more severe dissociative symptoms were associated with poorer treatment outcomes (Kleindienst et al. 2011).

#### Autism Spectrum Disorder

Information on individuals with autism spectrum disorder (ASD) and BPD is limited. Current evidence does not suggest that rates of BPD are increased in individuals with ASD or that rates of ASD are increased in individuals with BPD. However, there has been increasing recognition that distinguishing between BPD and ASD can be difficult because symptoms such as emotional dysregulation, relationship disruptions, and self-injurious behavior can occur in either diagnosis (Cheney et al. 2023; May et al. 2021). In addition, when both disorders are present, features of ASD can make it more difficult for patients to engage in psychotherapy for BPD (Cheney et al. 2023; May et al. 2021).

#### Treating Patients During Pregnancy and the Postpartum Period

Individuals with childbearing potential and at risk for pregnancy should be assisted in obtaining effective contraception if pregnancy is not desired. For patients who are planning to become pregnant, are pregnant, or are in the postpartum period, collaborative discussion of treatment options is essential. In addition to the patient, such discussions typically include the obstetrician-gynecologist or other obstetric practitioner, the infant's pediatrician for individuals who are breastfeeding, and, if involved, a partner or other people in the patient's support network. The overall goal is to develop a plan of care aimed at optimizing outcomes for both the patient and the infant. Untreated or inadequately treated maternal psychiatric illness can result in poor adherence to prenatal care, inadequate nutrition, increased alcohol or tobacco use, and disruptions to the family environment and mother-infant bonding (ACOG Committee on Practice Bulletins—Obstetrics 2008; American Academy of Pediatrics and the American College of Obstetricians and Gynecologists 2017; Tosato et al. 2017). In addition, during pregnancy and postpartum, frequent reassessment will be needed to determine whether any modifications to the treatment plan are indicated. As with all individuals who are pregnant, regular prenatal care is essential to ensuring optimal outcomes (American Academy of Pediatrics and the American College of Obstetricians and Gynecologists 2017; American College of Obstetricians and Gynecologists 2018).

In patients with BPD, psychotherapy is the primary focus of treatment, and it may be possible to avoid use of or discontinue medications prior to conception, during pregnancy, or while breastfeeding. All psychotropic medications studied to date cross the placenta, are present in amniotic fluid, and enter human breast milk (American Academy of Pediatrics and the American College of Obstetricians and Gynecologists 2017). If an individual becomes pregnant while taking a psychotropic medication, consideration should be given to consulting an obstetrician-gynecologist or maternal/fetal medicine



subspecialist in addition to discussion with the prescribing clinician to determine whether the risks of stopping the medication outweigh any possible fetal risks (American Academy of Pediatrics and the American College of Obstetricians and Gynecologists 2017; U.S. Food and Drug Administration 2011). For many patients, the period of greatest teratogenic risk (i.e., through the 8<sup>th</sup> week of gestation) will already have passed before prenatal care begins, and stopping psychotropic medication will not avoid or reduce teratogenic risk (American Academy of Pediatrics and the American College of Obstetricians and Gynecologists 2017). If medications are continued during pregnancy, physiological alterations of pregnancy affect the absorption, distribution, metabolism, and elimination of medications, and adjustments in medication doses may be needed (ACOG Committee on Practice Bulletins—Obstetrics 2008; Chisolm and Payne 2016).

Individuals who are taking medications and who wish to breastfeed their infants should review the potential benefits of breastfeeding as well as potential risks in the context of shared decision-making (American College of Obstetricians and Gynecologists' Committee on Obstetric Practice and the Breastfeeding Expert Work Group 2016; Sachs; Committee On Drugs 2013), with associated monitoring of growth and development by the infant's pediatrician (Sachs; Committee On Drugs 2013).

#### [Addressing Needs of Patients in Correctional Settings](#)

Rates of psychiatric illness, including BPD, are higher in correctional settings (e.g., prisons, jails, police lockups, detention facilities) than in the general population (Al-Rousan et al. 2017; Bebbington et al. 2017; Black et al. 2007; Nakic et al. 2022; Steadman et al. 2009; Wetterborg et al. 2015). Among individuals with BPD, criminal justice involvement may be especially likely in those with concomitant SUDs or antisocial personality disorder (Howard et al. 2021; Mir et al. 2015). Careful assessment and treatment planning are essential when individuals with a psychiatric condition are in correctional settings. Although some aspects of treatment may need to be adjusted to conform with unique aspects of correctional settings (Tamburello et al. 2018), many individuals experience gaps in care during incarceration (Epshteyn and Mahmoud 2021; Fries et al. 2013; Reingle Gonzalez and Connell 2014; Wilper et al. 2009). Access to treatment should be preserved, including treatment for concomitant SUDs (American Psychiatric Association 2007). Suicidal and non-suicidal self-injury are particular risks in the correctional system (Barker et al. 2014; Casiano et al. 2013; Young et al. 2006). In this regard, patients with BPD may also ingest objects or insert them into their body while incarcerated (Frei-Lanter et al. 2012; Mannarino et al. 2017; Masood 2021; Rada and James 1982; Reisner et al. 2013).

While in the correctional system, individuals with BPD may engage in disruptive behavior that results in disciplinary infractions (Yasmeen et al. 2022) and/or placement in a locked-down segregated setting in which inmates typically spend an average of 23 hours per day in a cell, have limited human interaction, and minimal or no access to programs (American Psychiatric Association 2017, 2018; American Public Health Association 2013; National Commission on Correctional Health Care 2016; Semenza and Grosholz 2019). Such settings offer little support or access to treatment due to security concerns and are likely to exacerbate rather than reduce disruptive behaviors (American College of Correctional Physicians 2013; American Psychiatric Association 2016b, 2017; American Public Health Association 2013; National Commission on Correctional Health Care 2016). Notably, rates of self-injury and suicide appear to be higher in such settings than elsewhere in the correctional system (Baillargeon et al. 2009b; Favril et al.

2020; Glowa-Kollisch et al. 2016; Kaba et al. 2014; Way et al. 2005), which is of particular concern in patients with BPD. Group treatment with Systems Training for Emotional Predictability and Problem Solving (STEPPS) has been studied in a correctional population and is associated with reductions in suicidal behaviors and disciplinary infractions although attrition rates were significant (Black et al. 2013, 2018).

Continuity of care is also important upon release from a correctional setting. This is particularly true for those who have been incarcerated for significant periods of time who will likely need assistance with domains such as housing, treatment needs, and financial support, including Medicaid benefits (American Psychiatric Association 2009; Baillargeon et al. 2009a, 2010; Draine et al. 2010; Wenzlow et al. 2011).

#### Statement 4 – Discussion of Diagnosis and Treatment

APA *recommends* **(1C)** that a patient with borderline personality disorder be engaged in a collaborative discussion about their diagnosis and treatment, which includes psychoeducation related to borderline personality disorder.

#### *Implementation*

Once a diagnosis of BPD has been established, it is important to discuss the diagnosis with the patient in a collaborative fashion that allows them to ask questions and share their experiences and perspectives. When treating an adolescent, parents or other involved caregivers will also be engaged in the discussion of the diagnostic impression. Clinicians are sometimes reluctant to document a diagnosis of BPD or share the diagnosis with patients out of concern for upsetting the patient, disrupting the therapeutic relationship, or contributing to discrimination towards the patient because of stigmas against individuals with BPD or psychiatric conditions, more generally (Lequesne and Hersh 2004; Proctor et al. 2021; Sims et al. 2022; Sisti et al. 2016; Sulzer et al. 2016). However, disclosure of and discussion of a diagnosis of BPD is preferred by patients (Proctor et al. 2021; Sulzer et al. 2016), does not adversely affect patient satisfaction (Zimmerman et al. 2018), is crucial on ethical grounds (AMA Code of Medical Ethics 2023b), and is part of good clinical practice. In addition, with the passing of the 21st Century Cures Act (Office of the National Coordinator for Health Information Technology 2020), clinical notes are required to be shared with patients except under very limited circumstances and proactively disclosing and discussing the diagnosis of BPD will aid patients in understanding their notes. For many patients, having access to notes and understanding the information that they contain fosters greater engagement in their own care (DesRoches et al. 2020).

Disclosing a diagnosis of BPD is also an initial step in discussing treatment options as well as in providing psychoeducation about BPD to patients. When psychoeducation is provided in a compassionate, nonjudgmental fashion, it can provide context and validation for the patient's experiences (e.g., in relationships, sense of self, emotional response). It is also important to ask about and understand the patient's beliefs about BPD and its features because patients may have internalized stigma or received misinformation related to the diagnosis (Koivisto et al. 2022; Masland et al. 2023). Typically, topics reviewed as part of psychoeducation include symptoms and behaviors that are often a part of the disorder and the expected types and course of treatment (American Psychiatric Association 2016a). For patients with BPD, it is particularly important to emphasize that treatment is effective (Ng et al. 2016,

2019a, 2019b). Many patients with BPD benefit from ongoing education about self-care (e.g., safe sex, potential legal problems, balanced diet) as well as education about crisis or safety plans. For patients who also have other concomitant disorders, by providing psychoeducation, these can also be discussed in terms of their features and treatments in the context of BPD. In addition to psychoeducation provided by the clinician, it can be helpful to share criteria from the DSM-5-TR (American Psychiatric Association 2022a), internet resources (Emotions Matter 2023a; Gunderson and Berkowitz 1991; National Education Alliance for Borderline Personality Disorder 2023c; National Institute of Mental Health 2023; New York Presbyterian Hospital 2023), or books on personality traits (Oldham and Morris 1995) or BPD (National Education Alliance for Borderline Personality Disorder 2023a) written for laypersons. More extensive psychoeducational intervention, consisting of workshops, lectures, seminars, or web-based programs may also be helpful.

Family members and other caregivers will often be a key part of the patient’s support network and care team, and this is particularly true when treating an adolescent. For this reason, family members and others in the support network will often benefit from educational materials about BPD or being directed to organizations that offer education and support (Emotions Matter 2023a; Mental Health America 2023; National Alliance on Mental Illness 2023; National Education Alliance for Borderline Personality Disorder 2023b; New York Presbyterian Hospital 2023). In addition to providing emotional support, such individuals may also be providing material support such as housing, financial assistance, insurance, transportation, childcare, or other assistance. They may be able to share observations about the patient’s symptoms or behaviors, help the patient in developing a safety plan, provide opinions about specific treatment approaches, or identify practical barriers to the patient’s ability to participate in treatment, such as limitations on insight, geographic issues, lack of transportation, childcare or caregiving responsibilities, financial or insurance coverage constraints, insufficient access to recommended treatment, or other systemic barriers to care. Psychoeducation for families should be distinguished from family therapy, which is sometimes a desirable part of the treatment plan and sometimes not, depending on the patient’s history and status of current relationships.

## Psychosocial Interventions

### Statement 5 – Psychotherapy

APA *recommends* **(1B)** that a patient with borderline personality disorder be treated with a structured approach to psychotherapy that has support in the literature and targets the core features of the disorder.

#### *Implementation*

Psychotherapy is at the core of treatment for BPD for adolescents and adults. A structured approach that has support in the literature is recommended. The specific psychotherapeutic approach that is selected should target the core features of the disorder.

With all psychotherapeutic modalities, it is important to foster a positive, trusting therapeutic alliance, convey a validating and non-judgmental attitude, and balance active support with an impetus to change and develop self-efficacy. Setting a framework for treatment is also crucial (see the Implementation section for Statement 3), although aspects of the therapeutic framework will depend on the type of

structured psychotherapy for BPD that is used. Teaching of skills and development of crisis plans are elements of treatment that are shared by many psychotherapies for BPD whereas other psychotherapies have a basis in psychodynamic principles and focus on helping patients use the therapeutic relationship to address problematic defensive patterns and understand their own and others' mental states (Bohus et al. 2021; Leichsenring et al. 2023). In adolescents and emerging adults, psychotherapy will typically need to address developmental issues (Sharp and Wall 2018) and incorporate family members or other caregivers as part of psychotherapy. For individuals of other age groups, family members and others in the patient's support network may also be involved in treatment. Developmental tasks may also warrant exploration at other points in the individuals' life.

Multiple structured approaches to psychotherapy are available and have been studied in patients with BPD (see Appendix C, Statement 5 and Appendix D); characteristics of these approaches are summarized in Table 3. Structured psychotherapies for BPD have an associated manual or protocol and typically incorporate ongoing supervision. These factors build on initial training and supervision in the use of a specific psychotherapy and help support delivery of treatment with a high degree of fidelity.

Although a number of structured approaches to psychotherapy that target BPD are superior to treatment-as-usual or wait-list control conditions, there is no clear evidence that any specific structured approaches to psychotherapy of BPD have significantly superior outcomes to other BPD-focused structured psychotherapeutic modalities in either adults or adolescents (Storebø et al. 2020; see Statement 5 in Appendix C). In addition, limited information is available on treatment of men or gender minorities or in non-White individuals or those with Hispanic ethnicity (Storebø et al. 2020; see Statement 5 in Appendix C). In the majority of studies that compare two active treatments, both types of psychotherapy are associated with clinical improvement, even when the outcomes of the therapies do not differ with respect to one another (see Appendices C and D). As such, selection of a treatment approach will depend on factors such as patient preferences for treatment, the availability of specific treatments, and the resource requirements of a treatment (Bohus et al. 2021; Choi-Kain et al. 2016, 2017). Under some circumstances, a patient may be unable to or prefer not to access a structured form of psychotherapy for BPD (e.g., due to availability, insurance coverage, affordability of a specific psychotherapy, other reasons related to logistics or patient preference). In this situation, less structured supportive psychotherapy may still produce clinical improvements via ongoing treatment engagement, including building a therapeutic alliance and providing psychoeducation (see Statement 3).

In terms of the optimal duration of psychotherapy for BPD, evidence is also limited in terms of the time needed to resolve interpersonal problems and attain and maintain lasting improvements in personality-related dysfunction and overall functioning. Most of the studies of structured psychotherapies for BPD have ranged in duration from 6-18 months (Storebø et al. 2020; see Appendix D). In one longitudinal study, a majority of patients continued in some form of outpatient treatment for much of a six-year period of follow-up (Zanarini et al. 2004b). Although other treatment trials have been of shorter duration, study participants often continue to receive other treatment including psychotherapy for BPD after the completion of research trials. In addition, a significant number of patients with BPD do not fully respond to initial treatment (Woodbridge et al. 2022) and may require longer periods of treatment. It is also unclear whether the optimal treatment duration may vary with specific BPD features, overall

severity, or with treatment intensity. For example, in an inpatient sample of individuals with BPD, many with co-occurring disorders, an intensive multi-modal therapeutic approach that incorporated a mentalization-based therapeutic model was associated with a significant degree of benefit on multiple outcomes with an average length-of-stay of 6 weeks (Fowler et al. 2018).

Table 3. Comparison of characteristics of psychotherapies for BPD.

Characteristic	Dialectical behavior therapy (DBT)	Dynamic deconstructive psychotherapy (DDP)	Mentalization-based treatment (MBT)	Schema-focused therapy (SFT)	Systems training for emotional predictability and problem solving (STEPPS)	Transference-focused psychotherapy (TFP)	Good psychiatric management (GPM)
Typical treatment duration	6-12 months	12-18 months	12-18 months	Depends on format	20 weeks	12-18 months	12 months
Individual therapy	1 hour/week	1 hour/week	1 hour/week	2 hours/week x 3 years	Not part of the treatment	2 45-50 minute sessions/week	Once weekly as needed
Group therapy	1.5 hour/week	Not part of the treatment	75-90 minutes/week	90 minutes/week x 8 months	2 hour/week	Used as indicated	Encouraged
Family therapy/involvement	Multi-family group for adolescents Family groups for adults	Not part of the treatment	MBT-Family MBT-Family Group Therapy	Not part of the treatment	1 hour session	Used as indicated	Family psychoeducation
Crisis management	Minimize ED use Focus on use of skills and skills coaching Between-session availability	Exploration in session	On call mentalizing team or ED after hours	Individualized plans	Use skills in group with referral to ED or individual therapist, as needed	Minimize ED use and use only when absolutely necessary	Crisis plan or algorithm regarding intersession contact
Manual available for treatment in adolescents	Yes	No	Yes	No	No	Yes	Yes
Comments	DBT skills training can be used independently from other DBT components			Delivered in an individual or group format but not both	Supplements other treatment		

ED=emergency department

DBT is a multicomponent approach that has efficacy in treating adolescents and adults with BPD but may also be useful in treating patients with other diagnoses who are at significant risk for suicide (Linehan 1993a, 1993b; Linehan et al. 2015). A key focus of DBT is to help patients develop a proactive problem-solving approach and learn to tolerate stress, regulate emotions, improve interpersonal effectiveness, and develop mindfulness (i.e., an ability to focus awareness on the present moment) as a way to address emotional dysregulation. At the core of the therapy is a philosophical dialectic between self-acceptance and strategies aimed at change. Skills worksheets and a specific protocol for addressing suicidal thoughts and behaviors are incorporated in the therapy. DBT is administered by a team of clinicians and is time-intensive for clinical teams as well as for patients. It typically includes 6-12 months of treatment with an hour of individual therapy and 90 minutes of group skills training weekly. Treatment team members are also available by cell phone for skills coaching between sessions. Weekly therapist consultation is an integral part of the treatment.

DBT skills training has also been studied as a standalone treatment and shows comparable effects to the full multicomponent approach to DBT when individual therapy was replaced with a case management intervention (Linehan et al. 2015). As a less intensive intervention, DBT skills training may be more accessible than multicomponent DBT. Manual assisted CBT, a 10-session intervention, can also be considered as a less intensive approach in the treatment of individuals with BPD (Davidson et al. 2014; Tyrer et al. 2004; Weinberg et al. 2006).

As the name implies, MBT focuses on mentalization, the ability to reflect on one's thoughts and feelings as well as those of others. Without such an ability, it is challenging to have a realistic emotional perspective on interpersonal events, particularly under stress. In MBT, the therapist guides the patient in learning to assess the emotional aspects of stressful interpersonal situations, such as those related to attachment, and then adopt a more realistic behavioral response (Bateman and Fonagy 2004, 2009; Jørgensen et al. 2013). The therapeutic relationship can also provide examples for working through these steps, although transference interpretations are not used. MBT typically includes 12-18 months of treatment with 50 minutes of weekly individual therapy and 75-90 minutes of group therapy. In adolescents, family therapy is incorporated in the treatment instead of group therapy. A weekly team meeting is also part of the treatment protocol.

TFP is a manualized, psychodynamically-oriented psychotherapy that uses the transference relationship to help address intense emotional states and difficulties in interpersonal relationships (Caligor et al. 2018; Clarkin et al. 2007; Doering et al. 2010; Giesen-Bloo et al. 2006; Yeomans et al. 2015). A core principle of TFP is the belief that internal images of the self in relation to others, based on developmental experiences, exist in the mind of all people. These mental images of self in relation to others are connected by strong emotions. In BPD, the internal mental images are extreme, intense, and polarized due to biological and developmental influences. "Transference" is the activation of these internal images in interactions with people. In the structured setting of therapy, this activation of the internal images of the self in relation to others can be observed and understood as they are experienced in relation to the therapist. This treatment model engages reflection on the emotions that are being experienced in the moment, along with reflection on the reasons that the images are extreme and polarized. This joint reflection on internal states helps the patient to modulate affects better and to

experience both the self and relations with others in a more complex and more realistic way. TFP typically includes 12-18 months of individual therapy delivered for 50 minutes twice weekly. TFP concepts and techniques can also be incorporated into other settings (Hersh et al. 2017). Supervision is recommended for clinicians who treat patients with TFP.

DDP is manualized individual psychotherapy (Gregory 2022; Gregory and Remen 2008), derived from psychodynamic psychotherapy, that uses the philosophical concept of deconstruction as a framework for treatment. Links to neurobiology and object relations are also part of the theoretical foundation of DDP. In DDP, therapeutic interventions focus on approaches such as alliance building, reflective listening, describing affect-laden experiences as simple narratives, recognizing and addressing polarized attributions, learning to assess oneself from an external perspective, and facilitating mourning of the limitations of oneself and others (Gregory 2022). Recent interpersonal experiences serve as primary examples for discussion although dream exploration, artwork, or creative writing can also be used. DDP typically includes 12-18 months of treatment delivered weekly for 45- to 50-minute sessions. Other interventions such as interpersonally-focused group therapy, art therapy, or 12-step programs can supplement DDP.

SFT is based on the concept that individuals view themselves and others in terms of cognitive “schemas” that are an outgrowth of developmental experiences and that manifest themselves in persistent patterns of thinking, feeling, and behaving, although they are often outside of conscious awareness (Arntz and van Genderen 2021; Farrell et al. 2009; Giesen-Bloo et al. 2006; Young et al. 2003). In BPD, dysfunctional “schema modes” are seen as strongly held and controlling a person’s life through recurring and rapidly shifting constellations of intense emotions, thoughts, feelings, and behavior. In SFT, these dysfunctional schema modes are addressed by fostering attachment between the patient and therapist as well as by applying behavioral, cognitive, and experiential techniques (including homework assignments). The treatment also incorporates emotional awareness training and psychoeducation. In addition, individualized plans for managing distress are created as part of treatment. In clinical trials, SFT has been delivered in individual 50-minute twice weekly sessions for three years (Giesen-Bloo et al. 2006) or in weekly 90-minute group sessions for 8 months (Farrell et al. 2009).

STEPPS is designed as a supplement to other treatment approaches and is delivered in a seminar format using detailed lesson plans (Bartels and Crotty 1992; Blum et al. 2008; STEPPS 2022). STEPPS consists of weekly 2-hour groups for 20 weeks as well as a single 2-hour session for families. It incorporates psychoeducation and skills training in emotional and behavioral management when viewed from the context of social and family systems. Participants are asked to monitor their thoughts, feelings, and behaviors over the course of the program to increase their awareness and identify improvements.

GPM uses a multimodal case management model in which BPD is understood as a reflection of interpersonal hypersensitivity (Gunderson et al. 2018; Links 2014; McMMain et al. 2009). As originally studied (McMMain et al. 2009), GPM was developed using psychodynamic principles. Treatment uses a generalist-model that emphasizes improvements in vocational and social functioning and incorporates psychoeducation about BPD as well as psychopharmacologic management, when clinically appropriate (Gunderson et al. 2018; Links 2014). The therapy uses a here-and-now approach in which the therapist



shows interest in the patient’s experiences and the interpersonal context and thoughts that precede feelings and behaviors. There is also a focus on the therapeutic alliance including attention to signs that a negative transference may be developing. GPM is typically delivered in once weekly sessions with weekly therapist supervision. An advantage of GPM is that it is relatively easy for clinicians to learn and apply (Bernanke and McCommon 2018; Hong 2016; Links et al. 2015). It has also been adapted for use with adolescents (Ilagan and Choi-Kain 2021). In addition, training in GPM may improve clinician attitudes about treating patients with BPD (Keuroghlian et al. 2016; Klein et al. 2022b; Masland et al. 2018).

## Pharmacotherapy

### Statement 6 – Clinical Review Before Medication Initiation

APA *recommends (1C)* that a patient with borderline personality disorder have a review of co-occurring disorders, prior psychotherapies, other non-pharmacological treatments, past medication trials, and current medications before initiating any new medication.

#### *Implementation*

Psychotherapy is the primary modality that is recommended for use in the treatment of BPD. As such, it is important to learn about past and current psychotherapies, including their types, fidelity to treatment principles, treatment intensity and duration, and the patient’s experience with therapy if this information was not already obtained as part of the initial evaluations (see Statement 1). Such information is helpful in determining whether a current psychotherapy can be optimized before adding medication, or whether a change in the psychotherapeutic approach may be needed.

Similarly, it is important to obtain information about prior medication trials, including their doses, durations, effectiveness, and associated adverse effects if this information was not already obtained as part of the initial evaluations (see Statement 1). A review of current medications is also important to determine whether the patient has been able to obtain, adhere to, and tolerate the medication. If the medication has been ineffective or if the response has been insufficient, it may be possible to increase the dose of the medication in an effort to achieve therapeutic benefit. Alternatively, if response has been minimal, it may be preferable to discontinue the medication and reassess the need for pharmacotherapy.

Half or more of BPD patients receive polypharmacy (Bridler et al. 2015; Gartlehner et al. 2021; Paris 2015; Romanowicz et al. 2020; Shapiro-Thompson and Fineberg 2022; Soler et al. 2022; Starcevic and Janca 2018), and drug-drug interactions may affect efficacy and tolerability by increasing or decreasing serum medication levels. Consequently, the medication regimen should be examined as a whole rather than only assessing the value of single medications as a part of the treatment plan.

In addition to reviewing past and current treatments, including other non-pharmacological treatments (e.g., ECT, TMS, light therapy), it is important to determine whether the patient has co-occurring psychiatric symptoms or disorders that warrant medication treatment (see the subsection “Addressing Co-Occurring Psychiatric Disorders” in Statement 3). Although patients with BPD often have co-occurring psychiatric disorders, such as mood disorders, PTSD, anxiety disorders, eating disorders, ADHD, SUDs,

and other personality disorders (Choi-Kain et al. 2022; Friborg et al. 2014; Geluk Rouwhorst et al. 2022; Grant et al. 2016; Gunderson et al. 2014; Keuroghlian et al. 2015; Leichsenring et al. 2011; Lenzenweger et al. 2007; McDermid et al. 2015; McGlashan et al. 2000; Miller et al. 2022; Momen et al. 2022; Santo et al. 2022; Tate et al. 2022; Trull et al. 2018; Zanarini et al. 2004a, 2010, 2019; Zimmerman et al. 2017), they may also exhibit symptoms such as impulsivity or mood dysregulation that are a reflection of BPD and not indicative of a co-occurring disorder. A careful history, including a family history of psychiatric illness and a longitudinal history of psychiatric symptoms or episodes, will facilitate appropriate diagnosis of co-occurring conditions when they are present without over-diagnosing (and over-treating) co-occurring conditions when they are not present.

### Statement 7 – Pharmacotherapy Principles

APA *suggests* **(2C)** that any psychotropic medication treatment of borderline personality disorder be time-limited, aimed at addressing a specific measurable target symptom, and adjunctive to psychotherapy.

#### *Implementation*

Despite the lack of evidence in support of medication treatment from clinical trials (see Appendix C, Statement 7 and Appendix D; Gartlehner et al. 2021; Stoffers-Winterling et al. 2022), there may be circumstances in which treatment with a medication may be considered on clinical grounds. For example, medication to address co-occurring disorders will generally be appropriate to use (see the subsection “Addressing Co-Occurring Psychiatric Disorders” in Statement 3). In other circumstances, pharmacotherapy may be used on a time-limited basis as an adjunct to psychotherapy for BPD and may help diminish symptoms such as affective instability, impulsivity, or psychotic-like symptoms in individual patients, helping them to remain engaged in treatment or reducing short-term risks of self-harm.

Selection of a medication, if one appears to be appropriate, will depend on the BPD symptom or symptoms that are being targeted or on the typical recommended treatments for a co-occurring condition. For example, in a patient with co-occurring MDD or OCD, an SSRI may be appropriate to use. For treatment of BPD symptoms, a low dose of a second-generation antipsychotic medication may be used in patients with psychosis, high levels of impulsivity, or agitation (Bohus et al. 2021). For extremely ill hospitalized patients with BPD (with or without psychotic symptoms), clozapine may be considered based on case reports, naturalistic data, and a small clinical trial (Chengappa et al. 1999; Crawford et al. 2022; Rohde et al. 2018). Anticonvulsant mood-stabilizing medications are sometimes used but have limited evidence of efficacy in individuals with BPD without co-occurring mood disorders (Gartlehner et al. 2021; Crawford et al. 2018). Use of benzodiazepines is not generally recommended because of potential for greater impulsivity or disinhibition as well as potential for misuse or development of dependence (Leichsenring et al. 2023; Lieslehto et al. 2023; Pascual et al. 2023). Decisions about medication should also consider potential risks of toxicity in overdose or potential for misuse, particularly in individuals with a co-occurring SUD. In addition, before treating a co-occurring disorder, a thorough assessment is still needed to establish the diagnosis and determine target symptoms for ongoing monitoring.

Prior to prescribing a medication, it is important to educate patients about the adjunctive nature of the medication in treating BPD symptoms and its potential benefits and adverse effects. In particular, medications would not be expected to affect core features of BPD. In addition, response of co-occurring conditions to medications may be less in individuals who also have BPD. Over-reliance on medication can send the erroneous message that emotional responses can be addressed by pharmacotherapy. Frequent dose escalation or medication changes in response to crises or transient mood states are also problematic and rarely effective. Potential adverse effects of specific medications should be reviewed prior to treatment initiation. Examples include risk of metabolic syndrome, weight gain, extrapyramidal side effects, or tardive dyskinesia with antipsychotic agents; risk of neural tube defects with divalproex use early in pregnancy; risk of polycystic ovary disease with divalproex in individuals with ovaries; risk of Stevens Johnson syndrome with lamotrigine; cognitive effects with topiramate. In adolescents, clinical trials of medications to treat BPD have not been conducted and side effects of medications may be more problematic.

If a medication is started, the duration of treatment should be time-limited with tapering and discontinuation of the medication, if possible, once symptoms have stabilized. While treatment is occurring, however, patients should receive any monitoring that is necessary for the specific medication (e.g., serum levels for some anticonvulsants, metabolic monitoring for antipsychotics).

Communication with other members of the treatment team is an essential aspect of decision-making about medications. Treatment team members and other collateral sources of information (e.g., family members) can provide ongoing observations about symptom response, in addition to direct observation and feedback from the patient. It is also important to communicate with other health professionals, such as primary care clinicians, who may be unaware of the complexities of prescribing medications to individuals with BPD and may inadvertently prescribe unwarranted medications.

#### Statement 8 – Pharmacotherapy Review

APA *recommends* **(1C)** that a patient with borderline personality disorder have a review and reconciliation of their medications at least every 6 months to assess the effectiveness of treatment and identify medications that warrant tapering or discontinuation.

#### *Implementation*

Appropriate use of pharmacotherapy for BPD includes prescribing as few medications as possible, using medication as an adjunct to treatment with psychotherapy, and selecting medications based on their ability to target specific and prominent symptom clusters (Gartlehner et al. 2021; Yadav 2020). Continuous review and reconciliation of medications is critical for avoiding or mitigating prolonged and unnecessary exposure to pharmacotherapy as well as inappropriate polypharmacy (Bridler et al. 2015; Gartlehner et al. 2021; Paris 2015; Romanowicz et al. 2020; Shapiro-Thompson and Fineberg 2022; Soler et al. 2022; Starcevic and Janca 2018). Medication reconciliation is a recommended best practice in hospital as well as outpatient settings (Institute for Safe Medication Practice 2023; The Joint Commission 2022).

Medication review has been suggested as an important part of optimizing therapeutic benefit for patients with BPD and should involve a structured, critical assessment of all medications prescribed, including among patients also participating in psychotherapy (Kadra-Scalzo et al. 2021). It is especially useful following stabilization of an acute crisis, as this is often a precipitating event that prompts medication initiation and once resolved, might preclude the need for continued pharmacotherapy (Starcevic and Janca 2018). Medication monitoring and review is an important strategy for early identification of drug–drug interactions and adverse reactions, the latter of which could lead to symptom exacerbation (e.g., use of benzodiazepines to reduce anxiety may exacerbate disinhibition and cognitive deficits) (Fineberg et al. 2019). Medication review is also necessary given the natural course of BPD, wherein symptoms fluctuate in intensity and frequency and may remit rapidly (Fineberg et al. 2019; Videler et al. 2019). In addition, patients may improve with psychotherapy and no longer require the same medications or medication doses. Thus, patients taking medication need to be monitored carefully and routinely to determine treatment response and taper or discontinue as needed (Fineberg et al. 2019). Ongoing reevaluation of the risks and benefits of a patient’s current medication should continue throughout treatment, especially given that some symptoms may resolve spontaneously (Ripoll 2013).

Appropriate use of pharmacotherapy for patients with BPD should also include a plan for deprescribing, such as tapering strategies and ongoing monitoring for changes in clinical presentation and adverse reactions (Fineberg et al. 2019; Shapiro-Thompson and Fineberg 2022). An effective plan for deprescribing includes making a list of medications—such as dose, route of administration, duration, expected benefits, adverse reactions, and potential for withdrawal symptoms with discontinuation—and working collaboratively with the patient to weigh the risks and benefits of tapering or discontinuing the medication (Chanen and Thompson 2016; Fineberg et al. 2019).

## Areas for Further Research

### Methodological Issues

Our ability to draw clinically meaningful conclusions and conduct meta-analyses from research on BPD would be augmented by improvements in the design of studies. Specific steps that could be taken might include:

- Improve the generalizability of study populations in terms of factors such as age, gender, sexual orientation, race, ethnicity, culture, social determinants, presence of co-occurring conditions, illness severity, and risk of suicidal, aggressive, or self-harming behaviors.
- Enhance study recruitment approaches and use a priori specification of analyses to obtain data on treatment effects in subgroups that have been under-represented in prior research (e.g., inpatients; older individuals; individuals with multiple psychiatric or physical health conditions; individuals with severe and/or persistent illness; diverse samples of individuals in terms of gender, sexual orientation, race, ethnicity, culture, neurodiversity, and social determinants).
- Develop approaches to data collection and transparent reporting of sociodemographic factors to facilitate pooling of data from multiple studies and permit assessment of treatment effects in subgroups that have been under-represented in previous research.
- Standardize definitions for and collection of key data elements and outcome variables, insofar as possible.
- Incorporate individuals with lived experience into identification of data elements and outcome variables to assure that research is assessing factors of importance to patients.
- Standardize information, insofar as possible, on patient characteristics that are important to risk adjustment of outcomes (e.g., age of illness onset, illness duration and severity, presence of specific symptoms or symptom clusters, type and frequency of self-harming behaviors, co-occurring conditions).
- Collect data on possible common mechanisms of psychotherapies (e.g., therapeutic alliance, therapist characteristics) in addition to elements that are hypothesized to relate to mechanisms of a specific psychotherapeutic approach.
- Report diagnostic information using both DSM-5-TR categorical diagnoses as well as using the AMPD.
- Integrate dimensional measures of AMPD and symptom domains of BPD (e.g., impulsivity, affect dysregulation) into clinical trial design.
- Provide detailed information on processes used for random assignment and masking or blinding to treatment condition.
- Report data separately, in so far as possible, for each diagnostic group in studies that use transdiagnostic samples.

- Augment self-report observations with clinician interpretation of the self-report and with direct measurements of outcome, insofar as possible.
- Assure that sample sizes in clinical studies are estimated a priori, and are adequate to achieve statistical power.
- Assure that studies report data in a consistent fashion with pre-specification of outcomes of interest.
- When observations are missing, use appropriate data analytic approaches and perform sensitivity analyses, when indicated, to determine the effects of missing data.
- Identify instruments for measuring BPD symptoms and features that are efficient, accurate, and culturally-sensitive, and validated in multiple languages for measuring key categorical and dimensional outcomes; foster standardized and consistent use of such instruments across studies.
- Identify standardized approaches for collecting information about factors that ultimately may be useful in individualizing treatment selection (e.g., biomarkers, family history, symptom history, treatment history, personality traits, self-harming behaviors).
- Assure that studies identify the magnitude of change in scale scores that would constitute a clinically meaningful difference.
- Increase collection of data on patient-centered outcomes (e.g., quality of life, social functioning, physical health, recovery) and select these outcomes using input from individuals with lived experience.
- Develop consensus definitions of response and remission of BPD that can be applied consistently across studies.
- Develop approaches to understanding the diversity of elements and indicators of recovery using insights from individuals with lived experience.
- Provide detailed descriptions of the characteristics of active treatments, including treatment-as-usual, when they are used in a comparative effectiveness study.
- For studies of new treatments or adaptations of existing treatments, use standardized versions of active comparison treatments to permit consistency in comparing treatments for non-inferiority.
- For studies of new treatments or adaptations of existing treatments, conduct comparative effectiveness studies with more than a single existing treatment to allow broader conclusions to be drawn about the relative effectiveness of different interventions.
- Assure that studies of new treatments, technologies, delivery system modifications, or clinical decision support systems include specific attention to health equity in implementation methods.
- Develop mechanisms such as registries for systematic collection of information on program outcomes as a complement to collecting clinical trial data.

- Incorporate approaches to study recruitment and treatment implementation to reduce the impact of placebo effects on study outcomes.
- Improve systematic collection of information on harms, including in studies of psychotherapies.
- Assure that studies assess longer-term treatment (e.g., at least 1 year) as well as long-term follow-up assessments (e.g., 3-5 years) to identify possible long-term harms and patterns of relapse after treatment completion.

## Research Topics

### Prevention, Screening, and Assessment

- Identify risk factors for development of BPD that could be used in defining subgroups of adolescents or adults who warrant prospective screening or could benefit from preventive interventions.
- Determine whether patient characteristics and symptoms can be used to identify adolescents or adults who would benefit from early intervention in order to prevent onset of BPD.
- Determine whether specific approaches to prevention (e.g., in high-risk adolescents) are associated with benefits on patient-oriented outcomes.
- Determine whether identification of BPD using targeted screening is associated with benefits on patient-oriented outcomes in adolescents and adults.
- Determine circumstances in which the AMPD is more useful than a categorical diagnosis of BPD or in which a categorical diagnosis of BPD is more useful than the AMPD.
- Determine whether additional screening, assessment, or longitudinal rating scales need to be developed for BPD to assure that their scores have reliability and can be interpreted as measures of a specific construct or outcome among a broad range of ages, genders, cultures, languages, symptom patterns, settings, treatment approaches, and diagnostic models (e.g., categorical, alternative model).

### Treatment Planning

- Determine ways to optimize short- and long-term patient outcomes in adolescents and adults, including recovery, using factors and approaches such as:
  - o early identification and intervention
  - o “stepped-care” or clinical staging approaches, which start with less intensive treatment and shift to more intensive interventions, as needed, to achieve recovery
  - o telehealth (individual, group, and family)
  - o setting specific interventions (e.g., emergency, inpatient, long-term care)
  - o large-scale data analytics and predictive algorithms

- o self-help and guided self-help approaches, including groups, manual-based approaches, or computer-based programs (including web-based, phone apps, chat bots, and other modalities)
  - o family/caregiver interventions, including support groups and psychoeducation
  - o involving certified peer support specialists as part of the multidisciplinary team
  - o modifying treatment to improve physical health and address co-occurring health conditions, including substance-related and addictive disorders and other psychiatric disorders
  - o modifying treatment to address significant symptoms such as suicidal ideas and behaviors, non-suicidal self-injury, aggressive behavior, anger, mood lability, or anxiety
  - o modifying treatment to address attachment-related issues or traumatic experiences, including adverse childhood experiences
  - o modifying treatment to address development-related issues in adolescents and emerging adults
  - o developing new treatments to target key aspects of personality in BPD.
- Identify clinical indicators, biomarkers, and other factors that can help in individualizing treatment selection, frequency, and duration to achieve optimal patient outcomes in adolescents and adults.
  - Identify clinical indicators, biomarkers, and other factors that can help in determining an optimal sequence of treatments, if an initial therapeutic modality is not associated with response or recovery.
  - Identify approaches to individualizing treatment selection and delivery to optimize outcomes for individuals of different ages, developmental stages, sexes, genders, races, ethnicities, and cultural groups, among other individual facets.
  - Obtain additional evidence in adolescents and adults on the optimal duration and frequency of treatments in relation to the severity of patient symptoms and other clinical variables.
  - Obtain additional evidence in adolescents and adults on novel or existing psychotherapies (e.g., interpersonal psychotherapy, acceptance and commitment therapy, DDP) in the treatment of BPD.
  - Obtain additional evidence in adolescents and adults on novel or existing psychotherapies in patients with common co-occurring disorders (e.g., PTSD, SUD, depression).
  - Obtain evidence on emerging therapeutic approaches such as psychedelic- or MDMA-assisted psychotherapy, which may facilitate the psychotherapeutic process by generating greater openness and self-compassion.
  - Obtain additional evidence in adolescents and adults on novel or existing pharmacotherapies in the treatment of BPD.



- Obtain additional evidence in adolescents and adults on novel or existing neurostimulation therapies, such as TMS, in the treatment of BPD.
- Conduct additional studies on the comparative effectiveness of psychotherapies and other interventions to treat BPD in adolescents and adults.
- Identify and standardize several effective psychotherapies for BPD in adults and adolescents that can then be used in a consistent fashion as an active comparator in comparative effectiveness studies.
- Conduct additional RCTs of treatment in adolescents and emerging adults.
- Identify optimal approaches to providing multidisciplinary team-based care of BPD in adolescents and adults with quantification of staff training and supervision requirements, cost-effectiveness, and program sustainability.
- Determine the circumstances in which “bundled” treatment programs are appropriate to use in adolescents and adults with BPD, including the elements of these programs that enhance patient outcomes.
- Identify clinical considerations in assessment and monitoring as well as optimal approaches to providing treatment to individuals with BPD who wish to become pregnant, are pregnant, or are breastfeeding.
- Determine which factors can be used in selecting an optimal treatment setting for adolescents and adults with BPD.
- Determine optimal monitoring frequencies and approaches to detect treatment-related benefits and adverse effects for adolescents and adults with BPD.
- Develop approaches to care that reduce relapse and avoid discontinuities in care for adolescents and adults with BPD.
- Identify the treatment elements and approaches that are viewed as most and least helpful by adolescents and adults who have responded to treatment of BPD.
- Identify differences in the characteristics of patients who seek or receive treatment with psychotherapy, pharmacotherapy, or both.
- Identify methods that will allow information from mobile technologies, wearable technology, and large-scale data analytics to inform assessment, treatment, and future research.
- Identify approaches to redesigning workflows and models of care delivery to improve the use of best practices and reduce inequities in the care of adolescents and adults with BPD.
- Determine the ways in which health system factors and treatment delivery characteristics influence patient outcomes for adolescents and adults with BPD.

- Develop approaches to the dissemination of training in effective psychotherapies.

#### Ethical Issues in BPD Assessment and Treatment

- Determine approaches for including individuals with lived experience in informing research goals, designs, methodologies, and interpretation, among other roles.
- Determine approaches for including family members or other caregivers of individuals with BPD in informing research goals, designs, methodologies, and interpretation, among other roles.
- Determine the optimal approaches to assess capacity to accept or decline treatment in patients with BPD.
- Determine optimal approaches (e.g., verbal communications, electronic information sharing via patient portals or open notes) for involving family in treatment while also protecting the privacy and confidentiality of adolescents and emerging adults.
- Identify ways in which social media influences BPD symptoms and treatment engagement in adolescents and adults.
- Determine whether specific policy recommendations, regulatory requirements, or adjustments to social media algorithms can reduce the deleterious effects of social media in adolescents and adults who have BPD.
- Identify ways in which risk factors, prevention, assessment, treatment, and outcomes of individuals with BPD are affected by internalized stigma and by biases and discrimination of society and health care professionals related to factors such as BPD and co-occurring diagnoses, physical health symptoms or conditions, age, gender, sexual orientation, race, ethnicity, culture, and social determinants.
- Identify effective approaches to reducing and eliminating health disparities due to bias and discrimination in the assessment and treatment of adolescents and adults with BPD.
- Determine whether specific policy recommendations, regulatory requirements, or health care service delivery interventions can reduce disparities in access to care based on factors such as age, gender, sexual orientation, race, ethnicity, culture, and social determinants as well as insurance status and geographic location.

## Guideline Development Process

This guideline was developed using a process intended to meet standards of the Institute of Medicine (2011) (now known as the National Academy of Medicine). The process is fully described in a document available on the APA Web site at: [www.psychiatry.org/psychiatrists/practice/clinicalpractice-guidelines/guideline-development-process](http://www.psychiatry.org/psychiatrists/practice/clinicalpractice-guidelines/guideline-development-process).

## Management of Potential Conflicts of Interest

Members of the Guideline Writing Group (GWG) are required to disclose all potential conflicts of interest before appointment, before and during guideline development, and on publication. If any potential conflicts are found or disclosed during the guideline development process, the member must recuse himself or herself from any related discussion and voting on a related recommendation. The members of both the GWG and the Systematic Review Group (SRG) reported no conflicts of interest. The Disclosures section includes more detailed disclosure information for each GWG and SRG member involved in the guideline's development.

## Guideline Writing Group Composition

The GWG was initially composed of six psychiatrists with general research and clinical expertise (G.A.K., J.M.A., S.B., J.M.L., R.M., M.S.). This non-topic-specific group was intended to provide diverse and balanced views on the guideline topic to minimize potential bias. Three psychiatrists (L.C.-K., K.J.N., J.M.O.) and one psychologist (C.S.) were added to provide subject matter expertise in BPD. One fellow (A.D.) was involved in the guideline development process. The vice-chair of the GWG (L.J.F.) provided methodological expertise on such topics as appraising the strength of research evidence. The GWG was also diverse and balanced with respect to other characteristics, such as geographical location and demographic background. Emotions Matter and National Council for Mental Wellbeing reviewed the draft and provided perspective from patients, families, and other care partners.

## Systematic Review Methodology

The methods for this systematic review follow the Agency for Healthcare Quality and Research (AHRQ) Methods Guide for Effectiveness and Comparative Effectiveness Reviews (available at <http://www.effectivehealthcare.ahrq.gov/methodsguide.cfm>) and the PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) checklist (Moher et al. 2015). The final protocol of this review was registered on PROSPERO (Registration #: CRD42020194098). All methods and analyses were determined a priori.

This guideline is based on an initial systematic search of available research evidence conducted by Dr. Evidence (Santa Monica, CA) using the DOC Data 2.0 software platform, and an updated search conducted by RTI. The systematic search of available research evidence used MEDLINE, Cochrane Library, EMBASE, and PsycINFO databases, with specific search terms and limits as described in Appendix B. Results covered the period from the start of each database to June 15, 2020, with additional searches in MEDLINE and PsycINFO through September 24, 2021. Search strategies used a variety of terms, medical subject headings (MeSH), and major headings, and were limited to English language and human-only studies (see Appendix B). Case reports, comments, editorials, and letters were excluded. To

minimize retrieval bias, we manually searched reference lists of landmark studies and background articles on this topic for relevant citations that electronic searches might have missed.

Studies were included if participants were  $\geq 13$  years of age and diagnosed with BPD as defined by DSM-IV, DSM-IV-TR, DSM-5 (Section II or Section III), or ICD-10, as applicable. Interventions of interest included psychotherapies, pharmacotherapies, and other interventions. Comparator conditions included active interventions, placebo, treatment as usual, waiting list controls, or GPM. Multiple outcomes were included related to key symptoms and domains of BPD, functioning, quality of life, adverse effects, and study withdrawal rates, among others (see Appendix B). Studies were excluded if BPD did not account for at least 75% of the total sample. Other exclusion criteria included small sample size ( $N < 50$  for non-randomized clinical trials or observational studies), lack of a comparator group, short treatment duration (less than 8 weeks), or studies done outside of very high Human Development Index (HDI) Countries. Citations to registry links, abstracts, and proceedings were not included unless also published in a peer-reviewed journal, because they did not include sufficient information to evaluate the risk of bias of the study.

For each trial identified for inclusion from the search, detailed information was extracted by RTI, with processes that included verifications and quality checks on data extraction. In addition to specific information about each reported outcome, extracted information included citation; study design; treatment arms (including doses, sample sizes); co-intervention, if applicable; trial duration and follow-up duration, if applicable; country; setting; funding source; sample characteristics (e.g., mean age, percent nonwhite, percent female, percent with co-occurring condition); and rates of attrition, among other data elements. Summary tables (see Appendices D and G) include specific details for each study identified for inclusion from the literature search. Factors relevant to risk of bias were also identified for each RCT that contributed to a guideline statement. Risk of bias was determined using the Cochrane Risk of Bias 2.0 tool (Sterne et al. 2019) and ratings are included in summary tables (see Appendix D) with specific factors contributing to the risk of bias for each study shown in Appendix E (McGuinness and Higgins 2021).

Available guidelines from other organizations were also reviewed (see Appendix F) (Canadian Agency for Drugs and Technologies in Health 2018; Herpertz et al. 2007; National Health and Medical Research Council 2012; National Institute for Health and Care Excellence 2009; Simonsen et al. 2019; The Finnish Medical Society Duodecim 2020).

### Rating the Strength of Supporting Research Evidence

*Strength of supporting research evidence* describes the level of confidence that findings from scientific observation and testing of an effect of an intervention reflect the true effect. Confidence is enhanced by such factors as rigorous study design and minimal potential for study bias.

Ratings were determined, in accordance with the AHRQ's Methods Guide for Effectiveness and Comparative Effectiveness Reviews (Agency for Healthcare Research and Quality 2014), by the methodologist (L.J.F.) and reviewed by members of the SRG and GWG. Available clinical trials were

assessed across four primary domains: risk of bias, consistency of findings across studies, directness of the effect on a specific health outcome, and precision of the estimate of effect.

The ratings are defined as follows:

- High (denoted by the letter A)=High confidence that the evidence reflects the true effect. Further research is very unlikely to change our confidence in the estimate of effect.
- Moderate (denoted by the letter B)=Moderate confidence that the evidence reflects the true effect. Further research may change our confidence in the estimate of effect and may change the estimate.
- Low (denoted by the letter C)=Low confidence that the evidence reflects the true effect. Further research is likely to change our confidence in the estimate of effect and is likely to change the estimate.

The AHRQ has an additional category of *insufficient* for evidence that is unavailable or does not permit estimation of an effect. The APA uses the *low* rating when evidence is insufficient because there is low confidence in the conclusion and further research, if conducted, would likely change the estimated effect or confidence in the estimated effect.

### Rating the Strength of Guideline Statements

Each guideline statement is separately rated to indicate strength of recommendation and strength of supporting research evidence. *Strength of recommendation* describes the level of confidence that potential benefits of an intervention outweigh potential harms. This level of confidence is informed by available evidence, which includes evidence from clinical trials as well as expert opinion and patient values and preferences. As described in the section “Rating the Strength of Supporting Research Evidence”), this rating is a consensus judgment of the authors of the guideline and is endorsed by the APA Board of Trustees.

There are two possible ratings: recommendation or suggestion. A *recommendation* (denoted by the numeral 1 after the guideline statement) indicates confidence that the benefits of the intervention clearly outweigh harms. A *suggestion* (denoted by the numeral 2 after the guideline statement) indicates greater uncertainty. Although the benefits of the statement are still viewed as outweighing the harms, the balance of benefits and harms is more difficult to judge, or either the benefits or the harms may be less clear. With a suggestion, patient values and preferences may be more variable, and this can influence the clinical decision that is ultimately made. These strengths of recommendation correspond to ratings of *strong* or *weak* (also termed *conditional*) as defined under the GRADE method for rating recommendations in clinical practice guidelines (described in publications such as Guyatt et al. 2008 and others available on the Web site of the GRADE Working Group at <http://www.gradeworkinggroup.org/>).

When a negative statement is made, ratings of strength of recommendation should be understood as meaning the inverse of the above (e.g., *recommendation* indicates confidence that harms clearly outweigh benefits).

The GWG determined ratings of the strength of the guideline statement by a modified Delphi method using blind, iterative voting and discussion. In order for the GWG members to be able to ask for clarifications about the evidence, the wording of statements, or the process, the vice-chair of the GWG served as a resource and did not vote on statements. The chair and other formally appointed GWG members were eligible to vote.

In weighing potential benefits and harms, GWG members considered the strength of supporting research evidence, their own clinical experiences and opinions, and patient preferences. For recommendations, at least 9 out of 10 members must have voted to recommend the intervention or assessment after 5 rounds of voting, and at most one member was allowed to vote other than “recommend” the intervention or assessment. On the basis of the discussion among the GWG members, adjustments to the wording of recommendations could be made between the voting rounds. If this level of consensus was not achieved, the GWG could have agreed to make a suggestion rather than a recommendation. No suggestion or statement could have been made if three or more members voted “no statement.” Differences of opinion within the GWG about ratings of strength of recommendation, if any, are described in the subsection “Balancing of Potential Benefits and Harms in Rating the Strength of the Guideline Statement” for each statement.

### Use of Guidelines to Enhance Quality of Care

Clinical practice guidelines can help enhance quality by synthesizing available research evidence and delineating recommendations for care on the basis of the available evidence. In some circumstances, practice guideline recommendations will be appropriate to use in developing quality measures. Guideline statements can also be used in other ways, such as educational activities or electronic clinical decision support, to enhance the quality of care that patients receive. Furthermore, when availability of services is a major barrier to implementing guideline recommendations, improved tracking of service availability and program development initiatives may need to be implemented by health organizations, health insurance plans, federal or state agencies, or other regulatory programs.

Typically, guideline recommendations that are chosen for development into quality measures will advance one or more aims of the Institute of Medicine's report on “Crossing the Quality Chasm” (Institute of Medicine 2001) and the ongoing work guided by the multistakeholder-integrated AHRQ-led National Quality Strategy by facilitating care that is safe, effective, patient-centered, timely, efficient, and equitable. To achieve these aims, a broad range of quality measures (Watkins et al. 2015) is needed that spans the entire continuum of care (e.g., prevention, screening, assessment, treatment, continuing care), addresses the different levels of the health system hierarchy (e.g., system-wide, organization, program/department, individual clinicians), and includes measures of different types (e.g., process, outcome, patient-centered experience). Emphasis is also needed on factors that influence the dissemination and adoption of evidence-based practices (Drake et al. 2008; Greenhalgh et al. 2004; Horvitz-Lennon et al. 2009a).

Measure development is complex and requires detailed development of specification and pilot testing (Center for Health Policy/Center for Primary Care and Outcomes Research and Battelle Memorial Institute 2011; Fernandes-Taylor and Harris 2012; Iyer et al. 2016; Pincus et al. 2016; Watkins et al.

2011). Generally, however, measure development should be guided by the available evidence and focused on measures that are broadly relevant and meaningful to patients, clinicians, and policy makers. Measure feasibility is another crucial aspect of measure development but is often decided based on current data availability, which limits opportunities for development of novel measurement concepts. Furthermore, innovation in workflow and data collection systems can benefit from looking beyond practical limitations in the early development stages in order to foster development of meaningful measures.

Often, quality measures will focus on gaps in care or on care processes and outcomes that have significant variability across specialties, health care settings, geographic areas, or patients' demographic characteristics. Administrative databases, registries, and data from electronic health records can help to identify gaps in care and key domains that would benefit from performance improvements (Acevedo et al. 2015; Patel et al. 2015; Watkins et al. 2016). Nevertheless, for some guideline statements, evidence of practice gaps or variability will be based on anecdotal observations if the typical practices of psychiatrists and other health professionals are unknown. Variability in the use of guideline-recommended approaches may reflect appropriate differences that are tailored to the patient's preferences, treatment of co-occurring illnesses, or other clinical circumstances that may not have been studied in the available research. On the other hand, variability may indicate a need to strengthen clinician knowledge or address other barriers to adoption of best practices (Drake et al. 2008; Greenhalgh et al. 2004; Horvitz-Lennon et al. 2009a). When performance is compared among organizations, variability may reflect a need for quality improvement initiatives to improve overall outcomes but could also reflect case-mix differences such as socioeconomic factors or the prevalence of co-occurring illnesses.

When a guideline recommendation is considered for development into a quality measure, it must be possible to define the applicable patient group (i.e., the denominator) and the clinical action or outcome of interest that is measured (i.e., the numerator) in validated, clear, and quantifiable terms. Furthermore, the health system's or clinician's performance on the measure must be readily ascertained from chart review, patient-reported outcome measures, registries, or administrative data. Documentation of quality measures can be challenging, and, depending on the practice setting, can pose practical barriers to meaningful interpretation of quality measures based on guideline recommendations. For example, when recommendations relate to patient assessment or treatment selection, clinical judgment may need to be used to determine whether the clinician has addressed the factors that merit emphasis for an individual patient. In other circumstances, standardized instruments can facilitate quality measurement reporting, but it is difficult to assess the appropriateness of clinical judgment in a validated, standardized manner. Furthermore, utilization of standardized assessments remains low (Fortney et al. 2017), and clinical findings are not routinely documented in a standardized format. Many clinicians appropriately use free text prose to describe symptoms, response to treatment, discussions with family, plans of treatment, and other aspects of care and clinical decision-making. Reviewing these free text records for measurement purposes would be impractical, and it would be difficult to hold clinicians accountable to such measures without significant increases in electronic medical record use and advances in natural language processing technology.

Conceptually, quality measures can be developed for purposes of accountability, for internal or health system–based quality improvement, or both. Accountability measures require clinicians to report their rate of performance of a specified process, intermediate outcome, or outcome in a specified group of patients. Because these data are used to determine financial incentives or penalties based on performance, accountability measures must be scientifically validated, have a strong evidence base, and fill gaps in care. In contrast, internal or health system–based quality improvement measures are typically designed by and for individual providers, health systems, or payers. They typically focus on measurements that can suggest ways for clinicians or administrators to improve efficiency and delivery of services within a particular setting. Internal or health system–based quality improvement programs may or may not link performance with payment, and, in general, these measures are not subject to strict testing and validation requirements. Quality improvement activities, including performance measures derived from these guidelines, should yield improvements in quality of care to justify any clinician burden (e.g., documentation burden) or related administrative costs (e.g., for manual extraction of data from charts, for modifications of electronic medical record systems to capture required data elements). Possible unintended consequences of any derived measures would also need to be addressed in testing of a fully specified measure in a variety of practice settings. For example, highly specified measures may lead to overuse of standardized language that does not accurately reflect what has occurred in practice. If multiple discrete fields are used to capture information on a paper or electronic record form, data will be easily retrievable and reportable, but oversimplification is a possible unintended consequence of measurement. Just as guideline developers must balance the benefits and harms of a particular guideline recommendation, developers of performance measures must weigh the potential benefits, burdens, and unintended consequences in optimizing quality measure design and testing.

### External Review

This guideline was made available for review June-July 2023 by the APA membership, scientific and clinical experts, allied organizations, and the public. In addition, a number of patient advocacy organizations were invited for input. Forty-seven individuals and 17 organizations submitted comments on the guideline (see the section “Individuals and Organizations That Submitted Comments” for a list of the names). The Chair and Vice-chair of the GWG reviewed and addressed all comments received; substantive issues were reviewed by the GWG.

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## Disclosures

The Guideline Writing Group and Systematic Review Group reported the following disclosures during development and approval of this guideline:

Dr. Keepers is employed as Professor and Chair of the Department of Psychiatry by Oregon Health & Science University. He receives travel funds from the American Board of Psychiatry and Neurology, the American College of Psychiatry, and the Accreditation Council for Graduate Medical Education related to his activities as a member or chair of various committees. He reports no conflicts of interest with his work on this guideline.

Dr. Fochtman is employed as a distinguished service professor of psychiatry, pharmacological sciences, and biomedical informatics at Stony Brook University and deputy chief medical information officer for Stony Brook Medicine. She also consults for the American Psychiatric Association on the development of practice guidelines. She reports no conflicts of interest with her work on this guideline.

Dr. Anzia is employed as Professor of Psychiatry and Behavioral Sciences and Residency Program Director/Vice Chair for Education at Northwestern University/Feinberg School of Medicine. She receives part of her salary from the Medical Staff Office of Northwestern Medicine for her role as Physician Health Liaison. Dr. Anzia receives travel funds from the American Board of Psychiatry and Neurology, the American College of Psychiatry, and the Accreditation Council for Graduate Medical Education for her activities as Board Director, committee chair, and various other committees. She has no conflicts of interest with her work on this guideline.

Dr. Benjamin is employed as Vice Chair for Education in Psychiatry at the University of Massachusetts T H Chan School of Medicine, where he is also Director of Neuropsychiatry, and Professor of Psychiatry and Neurology. He periodically receives honoraria for lectures, provides consultation to the Massachusetts Department of Mental Health, and serves as an expert witness on neuropsychiatric issues. He is a partner in and author for Brain Educators, LLC, a publisher of educational materials designed to improve neuropsychiatric assessment skills. Any income received is used to offset production and development costs of the materials. He is a psychiatry director of the American Board of Psychiatry and Neurology and receives a stipend in connection with this work. He reports no conflicts of interest with his work on this guideline.

Dr. Lyness is employed as President and CEO of the American Board of Psychiatry & Neurology. He has an unpaid position as Professor Emeritus of Psychiatry at the University of Rochester School of Medicine & Dentistry. Previously, he was employed as Senior Associate Dean for Academic Affairs and Professor of Psychiatry and Neurology in the School of Medicine & Dentistry at the University of Rochester Medical Center, received compensation as a Psychiatry Director of the American Board of Psychiatry & Neurology, and provided independent medical examinations for various attorneys. He is a paid contributor to several articles for UpToDate, Inc. He has no other relevant financial or fiduciary interests and reports no conflicts of interest with his work on this guideline.



Dr. Mojtabai is employed as Professor of Public Health at Johns Hopkins Bloomberg School of Public Health with joint appointment in the Department of Psychiatry and Behavioral Sciences in Baltimore, Maryland, and as a psychiatrist at Johns Hopkins Hospital. He has been a principal investigator and co-investigator on grants funded by the National Institute of Health. During the period of working on this guideline, he received royalties from UpToDate, Inc. and provided research consultation to Surgo Ventures as well as expert consultation regarding social media litigation on behalf of the Plaintiffs. He reports no conflicts of interest with his work on this guideline.

Dr. Servis is employed as Professor of Psychiatry and Behavioral Sciences and the Vice Dean for Medical Education at the University of California Davis School of Medicine. He consults to the Medical Board of California and serves on the Psychiatry Residency in Training Examination Editorial Board for the American College of Psychiatrists and the Interdisciplinary Review Committee for the USMLE Step 2 Examination for the National Board of Medical Examiners. He reports no conflicts of interest with his work on this guideline.

Dr. Choi-Kain is employed as the Director of the Gunderson Personality Disorder Institute at McLean Hospital as well as an Assistant Professor of Psychiatry at Harvard Medical School. The Gunderson Personality Disorders Institute has a training division, providing formal trainings in evidence-based treatments, consultations to teams, training of trainers, and supervision of clinicians using these treatments. Dr. Choi-Kain receives payments via McLean Hospital from government agencies in Canada, Australia, Sweden, and others for teaching. The other part of the institute is a research lab through which Dr. Choi-Kain receives funding from private funds as well as the National Alliance for Research on Schizophrenia & Depression/Brain & Behavior Research Foundation. She receives royalty from the sales of books on BPD, especially Good Psychiatric Management (GPM) from Springer and American Psychiatric Association Publishing. Her conflicts of interest with her work on this guideline include her work with GPM which has been informed by prior guidelines and will incorporate any changed guidelines.

Dr. Nelson is employed as Associate Professor of Psychiatry and Behavioral Sciences and Associate Designated Institutional Official at the University of Minnesota Medical School. Dr. Nelson receives Educational Research grant support and travel funds from the American Board of Psychiatry and Neurology. Other sources of financial income include honoraria from universities and health systems for providing Grand Rounds presentations on the topic of borderline personality disorder and other topics. Dr. Nelson has been compensated for providing consultative services in psychiatric education leadership and administration. Dr. Nelson receives royalties from UpToDate, Inc. for authoring the chapter on Pharmacology for Personality Disorders and for reviewing the chapters on Psychotherapy for Borderline Personality Disorder, Treatment of Antisocial Personality Disorder, and Psychotherapy for Schizotypal Personality Disorder. Dr. Nelson receives royalties from Oxford University Press for co-editing a book on the topic of schizophrenia. Dr. Nelson has not received financial support from the pharmaceutical or medical device industry and reports no conflicts of interest with her work on this guideline.

Dr. Sharp is the John and Rebecca Moores Professor and Associate Dean for Faculty and Research in the Psychology department and clinical program at the University of Houston. She is also the director of the

Developmental Psychopathology Lab and the Adolescent Diagnosis Assessment Prevention and Treatment (ADAPT) Center at the University of Houston. Dr. Sharp received funding from the National Institute of Mental Health and National Institute of Child Health and Human Development for several grants on which she is the PI (1R01MH127060-02, 1R01HD102436-01A1, R21MH128570), Co-I (1R01MH129354-01, 1I01CX002135-01A1), faculty sponsor (1F31HD108859-01A1, 1F31MH123127-01A1) or consultant (R21MH125052-01A1). She received honoraria for providing grand rounds and other types of educational activities related to her expertise in the developmental aspect of personality pathology. She receives royalties from Springer, American Psychiatric Association, Routledge, MIT Press and Guilford for books on the topic of personality pathology and related pathology and/or caregiving. She is editor of *Personality and Mental Health*, associate editor of *Personality Disorders: Theory, Research and Treatment*, and section editor for *Borderline Personality Disorder and Emotion Dysregulation*.

Dr. Degenhardt is a child and adolescent psychiatrist employed by the Fraser Health Authority specializing in emergency psychiatry and early psychosis. She is also a clinical instructor at the University of British Columbia. During the period of preparation of this guideline, she was employed by Vancouver Coastal Health as she completed her child and adolescent subspecialty training. She reports no conflicts of interest with her work on this guideline.

Dr. Oldham is a distinguished emeritus professor at Baylor College of Medicine and a senior consultant at The Menninger Clinic. He serves as editor for the *Journal of Psychiatric Practice*, co-editor for the *Journal of Personality Disorders*, and joint Editor-in-Chief for *Borderline Personality Disorder and Emotion Dysregulation*. He is an officer of NPSP25, LLC and a member of the Academic Advisory Board for Silver Hill Hospital. He reports no conflicts of interest with his work on this guideline.

## Individuals and Organizations That Submitted Comments

Hira Aslam, M.S., B.S.  
Bo Bach, Ph.D.  
Lee Anna Clark, Ph.D.  
John F. Clarkin, Ph.D.  
Katie Dixon-Gordon, Ph.D.  
Sarah Fineberg, M.D., Ph.D.  
Marianne Goodman, M.D.  
Paige Hector, L.M.S.W.  
Nathaniel Herr, Ph.D.  
Kimberly Hickey, B.A.  
Gabrielle Ilagan, M.A.  
Lisa Johnson, Ph.D.  
Anne Justus, Ph.D.  
Harold W. Koenigsberg, M.D.  
Paul S. Links, M.D., M.Sc, FRCPC  
Rebecca Mardis, B.S.  
Shelley McMain, Ph.D., C.Psych.  
H. George Nurnberg, M.D., DLFAPA  
Desmond Oathes, Ph.D.  
Jillian Papa, M.P.H.  
Joel Paris, M.D.  
K. Hogan Pesaniello, M.D.  
Alexandra Philipsen, M.D.  
Seth Pitman, Ph.D.  
Eric M. Plakun, M.D.  
Daniel Roberts, M.D., M.S.W.  
Craig Rodriguez-Seijas, Ph.D.  
Elsa Ronningstam, Ph.D.  
Shira Rubinstein, M.D.  
Anthony Ruocco, Ph.D.  
Philip S. Santangelo, Ph.D.  
Shannon Sauer-Zavala, Ph.D.  
Lori Scott, Ph.D.  
John Shemo, M.D.  
Jonathan Shepherd, M.D.  
Laika Simeon-Thompson, M.D.  
Andrew Skodol, M.D.  
Alexandra G. Stein, B.A.  
Saundra Stock, M.D.  
Paula Tusiani-Eng, M.Div. L.M.S.W.  
Grace Nayla, MRCPsych, ABPsych  
Kellyann May Navarre, B.A.  
Paula Jimena Zavala Billingsley Zaremba, M.H.S.  
Shirley Yen, Ph.D.  
Frank Yeomans, M.D.  
Mary Zanarini, Ed.D.  
Mark Zimmerman, M.D.  
APA Council on Research  
DSM Personality Disorder Work Group  
AMDA – The Society for Post-Acute and Long-Term Care Medicine  
American Academy of Physician Associates  
American Association of Geriatric Psychiatry  
American College of Neuropsychopharmacology

American Psychological Association  
American Society for Adolescent Psychiatry  
Association for Behavioral and Cognitive  
Therapies  
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Clinical TMS Society Clinical Standards  
Committee  
Emotions Matter  
European Society for the Study of  
Personality Disorders

International Society for the Study of  
Personality Disorders  
Maryland Psychiatric Society  
National Association of State Mental Health  
Program Directors  
National Council for Mental Wellbeing  
North American Society for the Study of  
Personality Disorders  
Royal Australian and New Zealand College  
of Psychiatrists