The American Psychiatric Association Practice Guideline for the Treatment of Patients With Borderline Personality Disorder

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At its December 2023 meeting, the American Psychiatric Association (APA) Board of Trustees approved "The American Psychiatric Association Practice Guideline for the Treatment of Patients With Borderline Personality Disorder." The full guideline is available at APA's Practice Guidelines website and describes aspects of guideline implementation that are relevant to individual patients' circumstances and preferences.

The goal of this guideline is to improve the quality of care and treatment outcomes for patients with borderline personality disorder (BPD), defined in Section II of the *Diagnostic and Statistical Manual of Mental Disorders*, 5th Edition, Text Revision (DSM-5-TR; American Psychiatric Association 2022). Despite a large number of studies on BPD, there are still substantial gaps in the availability of evidence-based treatments for individuals with BPD (Iliakis et al. 2019; Lohman et al. 2017) and misconceptions about the disorder (Baker and Beazley 2022; Sheehan et al. 2016; Stiles et al. 2023). 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 (Box 1) that are intended to enhance knowledge and optimize the assessment and treatment of BPD. 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, thereby reducing the mortality, morbidity, and significant psychosocial and health consequences of this important psychiatric condition.

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; Volkert et al. 2018; Zimmerman et al. 2017). Individuals with BPD are also frequent users of primary care and have elevated rates of chronic pain and other somatic conditions (Doering 2019; Heath et al. 2018; Tate et al. 2022). In general population samples, the lifetime prevalence of BPD in the United States is much lower, at 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).

Individuals with BPD commonly have other psychiatric disorders such as major depressive disorder, bipolar disorder, posttraumatic stress disorder (PTSD), anxiety disorders, eating disorders, attention-deficit/hyperactivity disorder, substance use disorders (SUDs), and other personality disorders (Friborg et al. 2014; McDermid et al. 2015; Tate et al. 2022; Trull et al. 2018; 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 that co-occurring disorder (Ceresa et al. 2021; Geluk Rouwhorst et al. 2023; Gunderson et al. 2014; Keuroghlian et al. 2015; Skodol et al. 2011).

In contrast to earlier views on BPD, this condition can remit, and symptoms can be reduced and managed. 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 with all-cause mortality (Kjær et al. 2020; Paris 2019; Schneider et al. 2019; Temes et al. 2019). Thus, 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 2022; Doering 2019; Leichsenring et al. 2011; Oldham 2006). In addition, individuals with BPD experience increases in health care costs related to BPD and to other physical conditions (Hastrup et al. 2019).

BOX 1. Guideline statements[a]

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 the 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 nonpharmacological 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 receive 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.

[a]A recommendation (denoted by the numeral 1 after the guideline statement) indicates confidence that the benefits of the intervention clearly outweigh the 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).

Additional burdens are related to the considerable amount of stigma that exists in relation to BPD, including self-stigma (Baker and Beazley 2022; Stiles et al. 2023). In addition, patients with BPD often experience discrimination within the health care system (Baker and Beazley 2022; Stiles et al. 2023). Bias about BPD is lessened and empathy for patients is increased when clinicians have received education about working with patients with this diagnosis (e.g., through seminars on good psychiatric management; Keuroghlian et al. 2016; Klein et al. 2022; Masland et al. 2018). Education can also be helpful in emphasizing that treatment 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).

OVERVIEW OF THE DEVELOPMENT PROCESS

This guideline was developed using a clearly defined and transparent process that is intended to be consistent with the recommendations of the 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 guideline appendices. The APA website features a full description of the guideline development process.

RATING THE STRENGTH OF RESEARCH EVIDENCE AND RECOMMENDATIONS

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). Our level of confidence in a guideline statement is informed by available evidence, which includes evidence from clinical trials (identified through systematic review) as well as expert opinion and patient values and preferences. In assessing available evidence, 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.

A detailed description of research evidence related to the effects of psychosocial interventions and pharmacological treatments in individuals with BPD can be found in the appendices accompanying the full guideline. For each guideline statement, the authors of the guideline have rated and 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. Each final rating was determined as described in the section "Guideline Development Process".

GUIDELINE SCOPE

This practice guideline focuses on evidence-based treatments for BPD. As such, 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 (American Psychiatric Association 1994, 2000, 2013; World Health Organization 1992). In addition, it includes statements related to assessment and treatment planning, which are an integral part of patient-centered care.

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. Our review included research with participants ages 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.

Data are also limited on the treatment of individuals with BPD who also have 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 examining 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.

The Alternative DSM-5 Model for Personality Disorders (AMPD; DSM-5-TR, Section III: "Emerging Measures and Models," American Psychiatric Association 2022) has had a significant impact in the realm of personality disorder assessment (Krueger and Hobbs 2020; Zimmermann et al. 2019) and is increasingly being integrated into clinical practice with adolescents as well as adults (Bach and Tracy 2022; Milinkovic and Tiliopoulos 2020; Oldham 2022; Sharp et al. 2022). 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 have not incorporated it into this version of the practice guideline but note it as an area that requires further treatment-related research.

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