BORDERLINE PERSONALITY DISORDER

BEHAVIORAL DEFINITIONS

1. A minor stress leads to extreme emotional reactivity (anger, anxiety, or depression) that usually lasts from a few hours to a few days.
2. A pattern of intense, chaotic interpersonal relationships.
3. Marked identity disturbance.
4. Impulsive behaviors that are potentially self-damaging.
5. Recurrent suicidal gestures, threats, or self-mutilating behavior.
6. Chronic feelings of emptiness and boredom.
7. Frequent eruptions of intense, inappropriate anger.
8. Easily feels unfairly treated and believes that others can't be trusted.
9. Analyzes most issues in simple, dichotomous terms (e.g., right/wrong, black/white, trustworthy/deceitful) without regard for extenuating circumstances or complex situations.
10. Becomes very anxious with any hint of perceived abandonment in a relationship.
11. Transient stress-related paranoid ideation or dissociation symptoms.

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LONG-TERM GOALS

1. Develop and demonstrate coping skills to deal with mood swings.
2. Develop the ability to control impulsive behavior.
3. Replace dichotomous thinking with the ability to tolerate ambiguity and complexity in people and issues.

4. Develop and demonstrate anger management skills.
5. Learn and practice interpersonal relationship skills.
6. Terminate self-damaging behaviors (such as substance abuse, reckless driving, sexual acting out, binge eating, or suicidal behaviors).

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SHORT-TERM OBJECTIVES

1. Discuss openly the history of cognitive, emotional, and behavioral difficulties that have led to seeking treatment. (1, 2, 3)

2. Disclose any history of substance use that may contribute to and complicate the treatment of borderline personality. (4)

THERAPEUTIC INTERVENTIONS

1. Assess the client's experiences of distress and disability, identifying behaviors (e.g., parasuicidal acts, angry outbursts, overattachment), affect (e.g., mood swings, emotional overreactions, painful emptiness), and cognitions (e.g., biases such as dichotomous thinking, overgeneralization, catastrophizing) that will become the targets of therapy.
2. Explore the client's history of abuse and/or abandonment, particularly in childhood years.
3. Validate the client's distress and difficulties as understandable given his/her particular circumstances, thoughts, and feelings.
4. Arrange for a substance abuse evaluation and refer the client for treatment if the evaluation recommends it (see the Substance Use chapter in this *Planner*).

3. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (5, 6, 7, 8)
5. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).
6. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
7. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
8. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as

	well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
4. Verbalize an accurate and reasonable understanding of the process of therapy and what the therapeutic goals are. (9, 10)	9. Orient the client to Dialectical Behavior Therapy (DBT), highlighting its multiple facets (e.g., support, collaboration, and coping/personal/interpersonal skills-building); its emphasis on exchange and negotiation, balancing the rational and emotional, and acceptance and change; as well as the dialectical/biosocial view of borderline personality, including constitutional and social influences (see *Cognitive-Behavioral Treatment of Borderline Personality Disorder* by Linehan).
	10. Throughout therapy, ask the client to read selected sections of books or manuals that reinforce therapeutic interventions (e.g., *Skills Training Manual for Treating Borderline Personality Disorder* by Linehan).
5. Verbalize a decision to work collaboratively with the therapist toward the therapeutic goals. (11)	11. Solicit from the client an agreement to work collaboratively within the parameters of the DBT approach including staying in therapy for the specified time period, attending scheduled therapy sessions, working toward reducing suicidal behaviors, and participating in skills training to address the behaviors, emotions, and cognitions that have been identified as causing problems in his/her life.

6. Verbalize any history of self-mutilation and suicidal urges and behavior. (12, 13, 14, 15)

12. Probe the nature and history of the client's self-mutilating behavior.

13. Assess the client's suicidal gestures as to triggers, frequency, seriousness, secondary gain, and onset.

14. Arrange for hospitalization, as necessary, when the client is judged to be harmful to self.

15. Provide the client with an emergency helpline telephone number that is available 24 hours a day.

7. Promise to initiate contact with the therapist or helpline if experiencing a strong urge to engage in self-harmful behavior. (16, 17)

16. Interpret the client's self-mutilation as an expression of the rage and helplessness that could not be expressed as a child victim of emotional abandonment or abuse; express the expectation that the client will control his/her response to the urge to self-mutilate.

17. Elicit a promise (as part of a self-mutilation and suicide prevention contract) from the client that he/she will initiate contact with the therapist or a helpline if a suicidal urge becomes strong and before any self-injurious behavior occurs; throughout the therapy process, consistently assess the strength of the client's suicide potential.

8. Reduce actions that interfere with participating in therapy. (18)

18. Continuously monitor, confront, and problem-solve client actions that threaten to interfere with the continuation of therapy such as missing appointments, noncompliance, and/or abruptly leaving therapy.

9. Cooperate with an evaluation by a physician for psychotropic medication and take medication, if prescribed. (19, 20)

10. Reduce the frequency of maladaptive behaviors, thoughts, and feelings that interfere with attaining a reasonable quality of life. (21)

11. Participate in a group (preferably) or individual personal/interpersonal skills development course. (22, 23)

19. Assess the client's need for medication (e.g., selective serotonin reuptake inhibitors) and arrange for prescription, if appropriate.

20. Monitor and evaluate the client's psychotropic medication prescription compliance and the effectiveness of the medication on his/her level of functioning.

21. Use validation, dialectical strategies (e.g., metaphor, devil's advocate), and cognitive-behavioral strategies (e.g., cost-benefit analysis, cognitive restructuring, personal and interpersonal skills training) to help the client manage, reduce, or regulate maladaptive behaviors (e.g., angry outbursts, binge drinking, abusive relationships, high-risk sex, uncontrolled spending), thoughts (e.g., all-or-nothing thinking, catastrophizing, personalizing), and feelings (e.g., rage, hopelessness, abandonment); see *Cognitive-Behavioral Treatment of Borderline Personality Disorder* by Linehan).

22. Conduct group or individual skills training tailored to the client's identified problematic behavioral patterns with an emphasis on emotional regulation, distress tolerance, interpersonal effectiveness, and mindfulness.

23. Use behavioral strategies to teach identified skills (e.g., instruction, modeling, advising), strengthen them (e.g., role-playing, exposure exercises),

and facilitate incorporation into the client's everyday life (e.g., homework assignments).

12. Discuss previous or current posttraumatic stress. (24)

24. After adaptive behavioral patterns and emotional regulation skills are evident, work with the client on remembering the facts of previous trauma, reducing avoidance or denial, increasing insight into its effects, reducing maladaptive emotional and/or behavioral responses to trauma-related stimuli, reducing self-blame, and increasing acceptance.

13. Identify, challenge, and replace biased, fearful self-talk with reality-based, positive self-talk. (25, 26, 27)

25. Explore the client's schema and self-talk that mediates his/her trauma-related and other fears; identify and challenge biases; assist him/her in generating thoughts that correct for the negative biases, accept uncertainty, and build self-confidence.

26. Assign the client a homework exercise in which he/she identifies fearful self-talk and creates reality-based alternatives; review and reinforce success, providing corrective feedback for failure (see "Journal and Replace Self-Defeating Thoughts" in the *Adult Psychotherapy Homework Planner* by Jongsma or "Daily Record of Dysfunctional Thoughts" in *Cognitive Therapy of Depression* by Beck, Rush, Shaw, and Emery).

27. Reinforce the client's positive, reality-based cognitive messages that reduce personal distress, enhance self-confidence, and increase adaptive action.

14. Participate in imaginal and/or in vivo exposure to trauma-related memories until talking or thinking about the trauma does not cause marked distress. (28, 29, 30, 31)

28. Direct and assist the client in constructing a hierarchy of feared and avoided trauma-related stimuli.

29. Direct imaginal exposure to the trauma in session by having the client describe a chosen traumatic experience at an increasing, but client-chosen level of detail; integrate cognitive restructuring and repeat until associated anxiety reduces and stabilizes; record the session and have the client listen to it between sessions (see "Share the Painful Memory" in the *Adult Psychotherapy Homework Planner* by Jongsma and *Dialectical Behavior Therapy in Clinical Practice* by Linehan, Dimeff, and Koerner); review and reinforce progress, problem-solve obstacles.

30. Assign the client a homework exercise in which he/she does an exposure exercise and records responses or listens to a recording of an in-session exposure (see *Dialectical Behavior Therapy in Clinical Practice* by Linehan, Dimeff, and Koerner); review and reinforce progress; problem-solve obstacles.

31. For client with comorbid PTSD, conduct prolonged exposure therapy, cognitive processing therapy, or eye movement desensitization and reprocessing (see the PTSD chapter in this *Planner*).

15. Verbalize a sense of self-respect that is not dependent on others' opinions. (32)

32. Help the client to clarify, value, believe, and trust in his/her evaluations of himself/herself,

	others, and situations and to examine them nondefensively and independent of others' opinions in a manner that builds self-reliance but does not isolate the client from others.
16. Engage in practices that help enhance a sustained sense of joy. (33)	33. Facilitate the client's personal and interpersonal growth and "capacity for sustained joy" by helping him/her choose experiences that strengthen self-awareness, personal values, and appreciation of life (e.g., engaging in value-consistent activities, spiritual practices, other relevant life experiences).
17. Learn and apply problem-solving skills to conflicts in daily life. (34)	34. Teach the client problem-solving skills (e.g., defining the problem clearly, brainstorming multiple solutions, listing the pros and cons of each solution, seeking input from others, selecting and implementing a plan of action, evaluating the outcome, and readjusting the plan as necessary); use role-playing and modeling to apply this skill to daily life situations (or assign "Plan Before Acting" in the *Adult Psychotherapy Homework Planner* by Jongsma).
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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	300.4	Dysthymic Disorder
	296.3x	Major Depressive Disorder, Recurrent
	_____	_____
	_____	_____
Axis II:	301.83	Borderline Personality Disorder
	301.9	Personality Disorder NOS
	799.9	Diagnosis Deferred
	V71.09	No Diagnosis
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Using DSM-5/ICD-9-CM/ICD-10-CM:

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
300.4	F34.1	Persistent Depressive Disorder
296.3x	F33.x	Major Depressive Disorder, Recurrent Episode
301.83	F60.3	Borderline Personality Disorder
301.9	F60.9	Unspecified Personality Disorder

Note: The ICD-9-CM codes are to be used for coding purposes in the United States through September 30, 2014. ICD-10-CM codes are to be used starting October 1, 2014. Some ICD-9-CM codes are associated with more than one ICD-10-CM and *DSM-5* Disorder, Condition, or Problem. In addition, some ICD-9-CM disorders have been discontinued resulting in multiple ICD-9-CM codes being replaced by one ICD-10-CM code. Some discontinued ICD-9-CM codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.