

# BORDERLINE PERSONALITY DISORDER

**Lionel Cailhol, Ludovic Gicquel & Jean-Philippe Raynaud**

Workshop of Peter Paul Rubens (about 1640), The Death of Dido, Getty Museum.

After piling a wooden effigy of her deceased husband in their matrimonial bed atop her own funeral pyre, Dido, the queen of Carthage, stabs herself with her lover Aeneas's sword. Virgil tells the story of her grief-stricken reaction to her abandonment by Aeneas.



Lionel Cailhol MD, PhD

Consultant psychiatrist,  
Psychiatric Emergency  
Service, General Hospital  
Center, Montauban & Clinical  
Investigation Center, Toulouse,  
France

Conflict of interest: none  
reported.

Ludovic Gicquel MD, PhD

Consultant child psychiatrist,  
Child Psychiatry, Henri Laborit  
Hospital Center, Poitiers &  
Professor of child psychiatry,  
University of Poitiers, France

Conflict of interest: none  
reported.

Jean-Philippe Raynaud MD

Consultant child psychiatrist,  
Child Psychiatry, University  
Hospital Center, Toulouse &  
Professor of child psychiatry,  
Paul Sabatier University,  
Toulouse, France

Conflict of interest: none  
reported.

This publication is intended for professionals training or practising in mental health and not for the general public. The opinions expressed are those of the authors and do not necessarily represent the views of the Editor or IACAPAP. This publication seeks to describe the best treatments and practices based on the scientific evidence available at the time of writing as evaluated by the authors and may change as a result of new research. Readers need to apply this knowledge to patients in accordance with the guidelines and laws of their country of practice. Some medications may not be available in some countries and readers should consult the specific drug information since not all dosages and unwanted effects are mentioned. Organizations, publications and websites are cited or linked to illustrate issues or as a source of further information. This does not mean that authors, the Editor or IACAPAP endorse their content or recommendations, which should be critically assessed by the reader. Websites may also change or cease to exist.

©IACAPAP 2012. This is an open-access publication under the [Creative Commons Attribution Non-commercial License](https://creativecommons.org/licenses/by-nc/4.0/). Use, distribution and reproduction in any medium are allowed without prior permission provided the original work is properly cited and the use is non-commercial. Send comments about this book or chapter to [jmreyATbigpond.net.au](mailto:jmreyATbigpond.net.au)

Suggested citation: Cailhol L, Gicquel L, Raynaud J-P. Borderline personality disorder. In Rey JM (ed), *IACAPAP e-Textbook of Child and Adolescent Mental Health*. Geneva: International Association for Child and Adolescent Psychiatry and Allied Professions 2012.

**B**orderline personality disorder (BPD) is characterised by a pervasive and persistent pattern of instability and impulsivity. BPD has enjoyed much research attention for several decades both in terms of understanding it and tackling it. Whilst the label of BPD is frequently used in clinic settings dealing with teenagers its use in the young remains controversial. Nevertheless, many believe that a set of converging arguments makes use legitimate in this age group (Miller et al, 2008).

From a didactic perspective, this chapter uses the concept of BPD as defined in DSM-IV. However, readers need to be aware of the risks of this reductionism in relation to other conceptualizations of the condition. In this chapter we highlight the high frequency of the disorder in adult and adolescent populations and its psycho-social consequences. A large section is dedicated to diagnosis and differential diagnosis. The chapter finishes with a description of useful treatment strategies.

## EPIDEMIOLOGY

### Prevalence

Prevalence of BPD is estimated to be between 0.7% and 1.8% (Swartz et al, 1990; Torgersen, 2001). A recent general population study involving about 35,000 participants found lifetime prevalence for BPD of 5.9% using the Alcohol Use Disorder and Associated Disabilities Interview Schedule-DSM-IV version (Grant et al, 1995). Within clinical populations, US data show a prevalence of 6.4% in general medical samples (Gross et al, 2002), and from 10% to 23% in out-patients suffering from mental health problems (Korzekwa et al, 2008; Swartz et al, 1990), and 20% among psychiatric inpatients.

Data are scarce for children and adolescents and samples are much smaller. A French study found a high prevalence of BPD in adolescents (10% in boys and 18% in girls) as measured by the DIB-R (Diagnostic Interview for Borderlines – Revised) adapted for adolescents (Chabrol et al, 2001a). A Chinese study reported a more modest prevalence of 2% (Leung & Leung, 2009).

### Gender and culture

Currently, prevalence in the general population is considered to be similar for both genders (Leichsenring et al, 2011). In clinical samples, females represent three quarters of all patients. Some experts hypothesize this may be due to men's difficulty accessing care, particularly psychotherapy (Goodman et al, 2010). This effect can also be seen in adolescents (Cailhol et al, in press). This is not a problem specific to BPD but found in other mental disorders also (O'Loughlin et al, 2011).

The concept of BPD originated in Western taxonomies (European and then North American). However, even in its definition, it runs into cultural difficulties. For example, the threshold for emotional lability may be different in Latin and Nordic countries and dissociative symptoms are not interpreted in the same way from one continent to the next. So, thresholds set by clinicians for each of the criteria may differ depending on their and their patients' culture. To our knowledge, the symptomatic expression of BPD in adolescence according to culture has barely been explored.

“Borderline patients have long been to psychiatry what psychiatry has been to medicine – a subject of public health significance that is under-recognized, undertreated, underfunded and stigmatized by the larger discipline. As with psychiatry and medicine, this is changing. New knowledge, new attitudes, and new resources promise new hope for persons with borderline personality” (Kernberg & Michels, 2009)

Through the International Classification of Diseases (ICD), the World Health Organisation (WHO) has promoted the use of this diagnosis throughout the world, in addition to validating an international tool for its diagnosis (Loranger et al, 1994). Nevertheless, the North American model (Diagnostic and Statistical Manual of Mental Disorders, DSM) dominates in research publications (Maffei, 2006). Scientists from different regions of the world continue to use the DSM diagnostic criteria as shown by recent publications, which highlights the issue of diagnosis according to culture (Rossier & Rigozzi, 2008; Wong et al, 2010). Migration does not seem to increase the risk of BPD (Pascual et al, 2008).

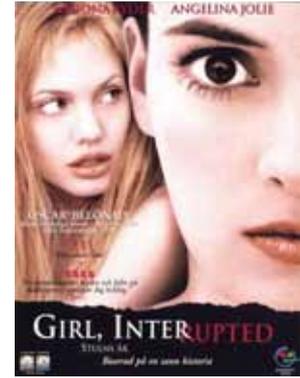
### **Burden of illness**

It is estimated that BPD costs up to 17,000€ a year per patient in direct and indirect costs in the Netherlands (van Asselt et al, 2007). This includes treatment, particularly hospitalisation, sick leave and loss of productivity. If prevalence in the general population is considered, costs would be substantial. Nevertheless, this European data cannot be extrapolated to the rest of the world as it reflects the medical-economic context in Western countries.

The consequences of BPD for the people around the sufferer depend on their vulnerability to the behaviour and demands of BPD individuals. Families of adolescents in particular need to tackle their child's demands for autonomy whilst protecting the youth and learn to manage worries related to risk-taking behaviour. This can cause considerable stress (Fruzzetti et al, 2005; Gerull et al, 2008; Hoffman et al, 2005).

Apart from physical complications ensuing from self-harming behaviours, BPD patients are exposed to risks due to their impulsivity – resulting in accidents, substance misuse and sexually transmitted diseases among others (Sansone et al, 1996; 2000a; 2000b; 2001). Finally, instability in emotional and inter-personal relationships leads to communication problems between parents and children (Guedeny et al, 2008; Hobson et al, 2005, 2009; Newman et al, 2007). Observational studies of mothers with BPD concerning attitudes towards their infants and young children show less availability, poorer organisation of behaviours and mood and lower expectations of positive interactions. These mothers are described more often as overprotective/intrusive and as less demonstrative/sensitive (Abela et al, 2005; McClellan & Hamilton, 2006; Newman et al, 2007). Their children experience higher rates of parental separation and loss of employment compared to those whose mothers suffer from depression or from other personality disorders.

The psychological development of children with BPD mothers is affected and they tend to withdraw from their surroundings (Abela et al, 2005; McClellan & Hamilton, 2006). These children are less attentive, interested or eager to interact with their mothers and demonstrate a more disorganised attachment in the Strange Situation Test (Abela et al, 2005). Children of mothers with BPD show high rates of suicidal thoughts (25%); the risk of children suffering from depression is seven times higher if the mother has a double diagnosis of depression and BPD (Bradley et al, 2005).



The concept of BPD has become part of cultural representations of Western populations: it has emerged in Facebook® and in artistic works (i.e., the book "Borderline" by Marie-Sissi Labrèche, or the film "Girl Interrupted" directed by James Mangold – based on Susanna Kaysen's account of her 18-month stay in a mental hospital).

## AGE OF ONSET AND COURSE

DSM-IV recommends that a diagnosis of BPD should not be made before the age of 18 years. In practice diagnosis is made earlier when symptoms are clear and persistent.

Follow up studies show that remission is common – 74% after 6 years; 88% after 10 years (Zanarini et al, 2003a, 2006) – questioning the notion that this is a chronic, unremitting condition. There appear to be two clusters of symptoms, one (characterised by anger, feelings of abandonment) tends to be stable or persistent while the other (characterised by self-harm and suicide attempts) is unstable or less persistent. It should be clarified that in most cases remission actually means a reduction in the number of symptoms below the diagnostic threshold and not necessarily the complete resolution of the disorder (Shea et al, 2002).

The risk of death by suicide in BPD patients is estimated at between 4% and 10%, one of the highest of any psychiatric illness. Suicide risk is higher in the event of co-occurrence with a mood disorder or substance abuse and with increasing number of suicide attempts (Paris, 2002). Suicide seems to occur late in the course of the disorder, around 30-37 years of age, and rarely during treatment (Paris, 2002).

These individuals' functioning is significantly impaired (e.g., Global Assessment of Functioning scale scores around 50), with frequent job losses, unstable relationships and history of rape (Zittel Conklin & Westen, 2005). Functioning is more impaired than in other Axis II disorders and in depression (Skodol et al, 2002; Zanarini et al, 2005).

Like in adults, remission is high when diagnosis is made during adolescence (Biskin et al, 2011); the peak frequency of BPD symptoms appears to be at 14 years of age (Chabrol et al, 2001b). However, in spite of the high remission rate, the presence of BPD in adolescence is far from harmless. Apart from the already mentioned complications inherent to the disorder, diagnosis increases the risk of other negative outcomes, for example, 80% of teenagers with BPD will suffer from a personality disorder in adulthood, even though BPD will occur in only 16% of them (Deschamps & Vreugdenhil, 2008).



Click on the picture to view Emily's history (10:43)

## CAUSES AND RISK FACTORS

The cause of BPD is unknown. However, several explanatory hypotheses can be found in the medical literature. The most widely accepted theories are psychogenic, mostly following psychoanalytic thinking. One of the initial explanations was based on the *object-relations theory* championed by Otto Kernberg (Clarkin et al, 2006). More recently, John Bowlby's *attachment theory* has provided further insights on the possible mechanisms underlining BPD (Bateman, 2004) while another view emphasizes the importance of *emotional dysregulation* (Linehan, 1993). Finally, *cognitive theories* highlight dysfunctional thinking patterns learnt in childhood, which are maintained in adulthood (Young, 1999). All these theories stress the importance of individuals' emotional development, scarred by trauma and emotional deficits, subsequent to a failure to adapt the environment to a child's needs.

At an epidemiological level, retrospective research has shown a significant prevalence of childhood trauma, sexual abuse, prolonged separations and neglect among patients with BPD (Zanarini et al, 1997). These experiences cannot be construed as direct causes of BPD. Although childhood trauma is high in this



She was born in 1926 and died in 1962 in tragic circumstances. She was an American actress that became a major sex symbol. She grew up with a mentally unstable mother who was financially unable to care for her. She was two years below the legal age when she married her first husband. She took numerous overdoses and had many passionate relationships. She underwent several psychological treatments and psychiatric hospitalizations.

population, it is not present in all cases and, when it does exist, it not always causes a BPD. Nevertheless, the high occurrence of early trauma has been used to support an alternative model of the disorder – as a traumatic disorder resulting from chronic childhood trauma (Golier et al, 2003). Figure H.4.1 illustrates the correlations between childhood abuse and post-traumatic stress disorder (PTSD) or BPD in adulthood. Without completely explaining the disorder, repeated childhood trauma seems to be a frequent element in BPD populations and among patients with PTSD. It should be highlighted also that about half the patients with BPD also meet criteria for PTSD.

Early maternal separation is associated with both BPD and the persistence of BPD symptoms over time (Crawford et al, 2009). Finally, BPD also has a genetic component; heritability is estimated at 47 % (Livesley, 1998). As in almost all psychiatric disorders, inheritance in BPD is polygenic. Further, interaction between genes and environment, as described in the preceding paragraphs, makes it difficult to interpret these data (Steele & Siever, 2010).

## DIAGNOSIS

### Clinical symptoms

In an effort to improve diagnostic reliability, DSM-III (American Psychiatric Association, 1981) introduced a multi-axial system, placed personality disorders on Axis II – alongside mental retardation – and described BPD as a separate diagnosis. According to DSM-IV (American Psychiatric Association, 1994), the main characteristics of BPD are instability and impulsivity, as described Table H.4.1. The International Classification of Diseases, 10<sup>th</sup> edition (ICD-10)

**Table H.4.1 Criteria and dimensions of borderline personality disorder**

	DSM-IV-TR CRITERIA	DIMENSION
6 -	Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).	Emotional
7 -	Chronic feelings of emptiness	
8 -	Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)	
3 -	Identity disturbance: markedly and persistently unstable self-image or sense of self.	Cognitive
9 -	Transient, stress-related paranoid ideation or severe dissociative symptoms	
4 -	Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). Note: Do not include suicidal or self-mutilating behaviour covered in Criterion 5.	Impulsive
5 -	Recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour	
1 -	Frantic efforts to avoid real or imagined abandonment. Note: Does not include suicidal or self-mutilating behaviour covered in Criterion 5.	Interpersonal
2 -	A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.	

(*Organisation Mondiale de la Santé*, 2000), places BPD within the “emotionally labile personalities” that include an impulsive sub-type (Table H.4.2). Both classifications require the behaviour pattern to be pervasive, to begin in adolescence or early adulthood and to cause significant impairment in functioning.

Both classifications, DSM and ICD, are currently being revised. The preliminary version proposes to retain BPD in DSM 5, while some other personality disorders are proposed for removal; this is discussed below in more detail.

### Subtypes

DSM-IV does not distinguish subtypes within BPD. Subtypes may be defined by the comorbidities. Nevertheless, some researchers propose two subtypes: dependent and impulsive. The former would be characterised by ambivalent, unstable relationships; the latter by a pattern of impulsive acts in multiple areas, including breaking the law. ICD-10, on the contrary, describes an impulsive and a borderline subtype (see Table H.4.2).



Multiple cuts are common in people with BPD

**Table H.4. 2 ICD-10 criteria for emotionally labile personality****F60.3 Emotionally unstable (borderline) personality disorder**

A personality disorder in which there is a marked tendency to act impulsively without consideration of the consequences, together with affective instability. The ability to plan ahead may be minimal, and outbursts of intense anger may often lead to violence or "behavioural explosions"; these are easily precipitated when impulsive acts are criticized or thwarted by others. Two variants of this personality disorder are specified, and both share this general theme of impulsiveness and lack of self-control.

**Impulsive type:**

The predominant characteristics are emotional instability and lack of impulse control. Outbursts of violence or threatening behaviour are common, particularly in response to criticism by others.

**Borderline type:**

Several of the characteristics of emotional instability are present; in addition, the patient's own self-image, aims, and internal preferences (including sexual) are often unclear or disturbed. There are usually chronic feelings of emptiness. A liability to become involved in intense and unstable relationships may cause repeated emotional crises and may be associated with excessive efforts to avoid abandonment and a series of suicidal threats or acts of self-harm (although these may occur without obvious precipitants).

**Presenting symptoms**

It is rare for patients to go to see their doctor complaining of BPD, even though publicity about the disorder in the media and Internet has started to make people more aware of this illness. Presentations are often prompted by another psychiatric problem (i.e., substance misuse, mood swings), problematic behaviour (i.e., abnormal eating, self-harm), or relationship problems. While self-harm decreases over time, it is a particularly useful identifying symptom in adolescence.

**From a categorical to a dimensional concept of BPD**

If we were to follow the DSM criteria to the letter, BPD would only be diagnosed in adults (Gicquel et al, 2011 ). However, some clinicians consider that this diagnosis can be made in adolescents with the proviso of accepting a lower predictive value than for adults (Bondurant et al, 2004). Aware of the shortcomings of current taxonomies, there has been a trend towards a dimensional conceptualization of the disorder. Table H.4.1 shows the diagnostic criteria and the four dimensions that have emerged from these criteria.

Although still in gestation, the fifth edition of the DSM will probably include a dimensional approach alongside the categorical one currently in use. To make a diagnosis of BPD it would be required (see Table H.4.3):

- (1) Significant impairments in *self* (identity or self-direction; this means how patients view themselves as well as how they identify and pursue goals in life) and *interpersonal* functioning (empathy or intimacy; meaning that an individual is able to understand other people's perspectives and form close relationships)
- (2) One or more pathological personality trait domains or trait facets
- (3) That are relatively stable across time situations
- (4) That symptoms are not better understood as normative for the individual's developmental stage or socio-cultural environment; and

**Table H.4.3: Summary of proposed diagnostic criteria for DSM-5 for borderline personality disorder** (as at December 2011; source: [DSM 5 Work Group](#))

1. A person must show significant impairment in two areas of personality functioning (from mild to extreme):
  - *Self* (identity, self-direction)
  - *Interpersonal* (empathy, intimacy)
2. Abnormal personality traits in at least one of these three areas:
  - *Negative affectivity*:
    - Unstable emotional experiences and frequent mood changes that are easily aroused, intense, or out of proportion to events and circumstances
    - Intense feelings of tension or panic, often in reaction to interpersonal stresses; feeling fearful, apprehensive, or threatened by uncertainty; fears of falling apart or losing control
    - Fears of rejection by – or separation from – significant others, associated with fears of excessive dependency and complete loss of autonomy
    - Frequently feeling down, miserable or hopeless and difficulty recovering from these moods; pessimism about the future; shame; feelings of inferiority; suicidal behaviour
  - *Disinhibition*:
    - Impulsivity: Acting on the spur of the moment; difficulty establishing or following plans; self-harming behaviour under emotional distress
    - Risk taking: Engaging in dangerous, risky, and potentially self-damaging activities
  - *Antagonism*: Persistent or frequent angry feelings in response to minor slights and insults
3. Impairment and personality traits are relatively stable across time and situations
4. Impairment is not consistent with developmental stage or socio-cultural environment
5. Symptoms are not due to substance use or a general medical condition.

- (5) Symptoms are not due to substance use or a general medical condition (e.g., severe head trauma).

Within this framework, personality disorders would lie at the extreme end of personality traits ranging from normal to pathological. Research by Zanarini et al (2007) highlights the stability of the disorder, the average duration of symptoms and the potential for remission and recovery, this is summarised in Table H.4.4.

It remains to be seen whether some adolescents experience “borderline moments” and whether others show marginal functioning or organisation. It is a fact that not all marginal adolescents develop BPD. This raises the question of the future of adolescents with marginal functioning. In this line, Bornovalova et al (2009) highlight the risk of diagnostic “labelling” of personality disorders in adolescents, a population undergoing many different developmental changes.

### Comorbidity

An international French-speaking study in adolescents led by the European Research Network on BPD (EURNET-BPD) found that BPD is very often comorbid with Axis I disorders: depression (71%), anorexia (40%), bulimia (33%), alcohol abuse (24%) and substance abuse (8%). In particular, comorbid ADHD may be an indicator of severity (Speranza et al, 2011). These data are similar to that reported for adults (Zanarini et al, 1998a). Data from the EURNET-

**Table H.4.4 Evolution of borderline personality disorder symptoms over time.**

SYMPTOMS	AVERAGE DURATION	
<ul style="list-style-type: none"> <li>• Para-psychotic manifestations</li> <li>• Risky sexual behaviour</li> <li>• Regression linked to treatment</li> <li>• Counter-transference problems, “special” treatment relations</li> </ul>	0 – 2 years	Acute symptoms
<ul style="list-style-type: none"> <li>• Abuse, dependence on psychoactive substances</li> <li>• Self-harm</li> <li>• Repeated suicide attempts</li> <li>• Demandingness</li> <li>• Severe identity disorder</li> </ul>	2 – 4 years	
<ul style="list-style-type: none"> <li>• Stormy relationships</li> <li>• Manipulation, sadism, devaluation</li> <li>• Emotional instability</li> <li>• Unusual perceptual experiences, strange thoughts</li> <li>• Feelings of abandonment, annihilation, collapse</li> <li>• Non hallucinatory paranoid experiences</li> </ul>	4 – 6 years	Temperamental symptoms
<ul style="list-style-type: none"> <li>• Major depressive episode, chronic depression</li> <li>• Chronic feelings of despair, guilt</li> <li>• Chronic anxiety</li> <li>• Overall impulsivity</li> <li>• Cannot bear to be alone</li> <li>• Conflict around dependence on care</li> <li>• Dependency, masochism</li> </ul>	6 – 8 years	
<ul style="list-style-type: none"> <li>• Chronic anger, frequent bouts of anger</li> <li>• Chronic feeling of solitude, emptiness</li> </ul>	8 – 10 years	

BPD group found that the highest Axis II comorbidity was for antisocial (22%) and avoidant personality disorders (21%), also similar to those found in adults (Zanarini et al, 1998b); there are gender differences in both adolescents and adults with a predominance of comorbid antisocial personality among boys.

### Psychometric evaluation

Many instruments exist to evaluate personality disorders in adults. These are the most widely used:

- SIDP-IV (Structured Interview for the Diagnosis of DSM-IV Personality Disorders) (Stangl et al, 1985). The DSM-IV version is widely used internationally (Pfohl et al, 1995) and has been used for adolescents (Chabrol et al, 2002)
- SCID-II (Structured Clinical Interview for DSM-IV) (First et al, 1997), complimenting SCID-I, which is used to diagnose Axis I disorders
- The IPDE (International Personality Disorders Examination; (Loranger et al, 1994) is a semi-structured interview that generates personality disorder diagnoses according to both ICD-10 and DSM-IV

- DIB-R (Diagnostic Interview for Borderline-Revised; Zanarini et al, 1990) is a semi-structured interview with 129 items. Although it does not diagnose DSM-IV BPD, it has satisfactory convergent validity with DSM-IV
- CAPA (Child and Adolescent Psychiatric Assessment) may also be relevant for BPD diagnosis (Renou et al, 2004).
- There are also self-report questionnaires that can be useful as screening instruments, such as the MSI-BPD (McLean Screening Instrument for BPD) and the PDQ-4+ (Personality Diagnostic Questionnaire) (Zanarini et al, 2003b, Hyler et al, 1989).

## TREATMENT

Two treatment guidelines for BPD are available, one by the American Psychiatric Association (2001) and another by the National Institute for Health and Clinical Excellence (NICE, 2009). Both have few recommendations specifically for adolescents.

### Aims

Setting a treatment plan and treatment goals is the first step in management, which will be influenced by the patient's instability. In practice, this will entail monitoring the patient's progress, working from a crisis management approach to deal with crisis and to manage harmful behaviour, progressing towards long term work on the personality aspects. At each stage a therapeutic contract is set up after needs and reasons for change are determined. Individualised aims would follow a hierarchy that needs to be explained to the adolescent. For example, reducing the risk of death would take precedence over treating symptoms or improving quality of life. Furthermore, adult caregivers need to be involved and assist in management (e.g., by removing toxic substances).

### Care framework

Treatment of adolescents with BPD *should usually be delivered as outpatient*. A sequential and eclectic approach offers a pragmatic solution to the clinical diversity and the natural evolution of the disorder (Gunderson, 2001). Determining the care framework thereby involves different aspects:

- Risk evaluation
- Mental state
- Level of psychosocial functioning
- Aims and motivation of the patient
- Social environment
- Comorbidity and
- Predominant symptoms.

Outpatient treatment can be delivered by an individual clinician, as a partnership between a treating psychiatrist and a psychotherapist, or in a day hospital setting, if available. It is helpful – as general rule – if psychotherapy and medication prescription are provided by different clinicians. Finally, the school can also play a role in the management of adolescents with BPD by offering stability and a place where they can build their identity and relationships, essential ingredients for these patients' improvement.



Click on the picture to access the NICE guideline

In practice, *inpatient treatment* can be considered for cases with severe comorbidity (e.g., addictions, severe depression) and when crisis management or day hospitalisation are unable to contain the patient. The risk of short term management of suicidality by admission to hospital, is that the patient regresses. Further, there is no effectiveness data.

### Biological treatments

According to the National Institute for Health and Clinical Excellence (NICE) (2009) guidance, drug treatment should not be used specifically for borderline personality disorder or for the individual symptoms or behaviour associated with the condition (for example, repeated self-harm, marked emotional instability, risk-taking behaviour and transient psychotic symptoms). However, comorbid disorders may require medication treatment. In addition, side effect profiles, compliance and the risk of incorrect usage limit the usefulness of medication. Finally, to our knowledge, no drug has been approved for BPD treatment, for adults or adolescents. These precautions highlight the limited role of psychotropic drugs in the overall care of BPD.

Apart from expert opinion, several meta-analyses provide guidance (Binks et al, 2006a; Ingenhoven & Duivenvoorden, 2011; Mercer, 2007; Nose et al, 2006; Rinne & Ingenhoven, 2007; Stoffers et al, 2010). The substances studied include neuroleptics, antidepressants, omega-3 fatty acids and anticonvulsants. However, the short duration of the trials, the low number of studies, the high number of subjects lost to follow up, the absence of comparative studies, and restrictive inclusion criteria in most of the controlled trials limit the interpretation of the results.

As far as benzodiazepines are concerned, they can be used in one-off situations but have considerable risk for addiction or disinhibiting these patients (American Psychiatric Association, 2001). In general, sedatives should not be prescribed for more than a week to deal with a crisis (National Institute for Health and Clinical Excellence, 2009). This explains the need for intensive monitoring and regular treatment review to identify unhelpful medications and their cautious and gradual removal. Antipsychotic drugs, in particular, should not be used for medium- or long-term treatment (National Institute for Health and Clinical Excellence, 2009). However, in the short-term, antipsychotics can have beneficial effects on cognitive-perceptual symptoms, anger, and mood lability (Ingenhoven & Duivenvoorden, 2011).

### Psychotherapy

Psychotherapies used to treat BPD share many aspects. For example, most highlight the importance of drawing a care contract at the start of therapy, including ways of dealing with risk situations, particularly suicidal crises, and contact between sessions (e.g., telephone), which must be agreed upon.

When considering psychological treatment for a person with BPD, clinicians should take into account (National Institute for Health and Clinical Excellence, 2009):

- Patients' choice and preference
- Degree of impairment and severity
- Patients' willingness to engage with therapy and their motivation to change

### Tips for treatment

**Support.** Given the high demands these patients place on clinicians, working in a team makes it easier to manage them. If a team is not available, regular supervision or access to colleagues for advice is highly recommended.

**Continuity.** Continuity of care over time is essential since treatment usually lasts years rather than weeks or months. Building a therapeutic relationship requires reliability from the professionals providing care.

**Clear framework.** Both clinician and patients must have a clear understanding of their work, its limits and how they will go about it.

**Responsibility.** While patients' behaviour and even diagnosis encourage systems (family, therapists, institutions) to take responsibility away from patients, it is useful to remember that increasing their emotional control involves gradually accepting more responsibility.

- Patients' ability to remain within the boundaries of a therapeutic relationship
- The availability of personal and professional support.

A variety of psychotherapy approaches have been used for BPD, including individual, group, and crisis treatments. There is no evidence to suggest that one specific form of psychotherapy is more effective than another (Binks et al, 2006b; Leichsenring & Leibing, 2003; Leichsenring et al, 2011).

*Dialectical Behavior Therapy* (DBT) – developed by Linehan from 1991 onwards – involves an integrative approach (behavioural, cognitive and mindfulness) grounded on a bio-psycho-social understanding of the disorder, where emotional regulation is considered the main problem (see Box). Only the first part of the treatment – dealing with the management of self-harming behaviours – has been validated.

*Schema Focused Therapy* (SFT) seeks to extend CBT principles to the treatment of personality disorders by placing greater emphasis on the therapeutic relationship, affect and mood states, lifelong coping styles (e.g., avoidance and overcompensation), entrenched core themes (i.e., maladaptive schemas, which develop when specific, core childhood needs are not met), and more discussion of childhood experiences and developmental processes. One study found that after three years of treatment SFT was more effective than a psychodynamically-based transference-focused psychotherapy for participants with BPD (Giesen-Bloo et al, 2006).

#### **Dialectic behaviour therapy (DBT)**

DBT was developed specifically for individuals with self-harm behaviours, such as self-cutting, suicidal thoughts and suicide attempts. Many patients with these behaviours have BPD. A key assumption in DBT is that self-destructive behaviours are learned coping techniques to manage unbearably intense and negative emotions. An invalidating environment is also a major contributing factor. An invalidating environment refers to the failure to treat a person in an attentive, respectful and understanding manner. Invalidating environments range from a poor fit between child and parents (e.g., a shy child growing up in a family of extroverts who tease her about her shyness) to extremes of physical or emotional abuse.

DBT provides patients with individual therapy, a skills group and phone coaching. Individual therapy entails once weekly individual sessions. Patients must also attend a two-hour weekly skills group for at least one year and are asked to call their individual therapists for skills coaching prior to hurting themselves. The therapist then walks them through alternatives to self-harming.

The three fundamentals of DBT are CBT, acceptance and dialectics. Learning new behaviours is critical in DBT and is a focus in every individual session, skills group or phone call (for coaching). There are several levels and types of acceptance (validation), from being respectful to what patients are saying, feeling, and doing to treating the patient as an equal (i.e., as opposed to being treated like a fragile mental patient). "Dialectics" assumes that everything is connected to everything else, change is constant and inevitable, and that opposites can be integrated.

*Mentalization Based Treatment* (MBT) is a psychodynamic therapy developed by Bateman and Fonagy (1999, 2004). “Mentalization” in this model means the ability to differentiate and separate out one’s own thoughts and feelings from those of other people around. The various aspects of mentalization are emphasized in MBT, are reinforced and practiced within a supportive psychotherapy setting. Because the approach is psychodynamic, therapy tends to be less directive than CBT-based treatments.

*Transference Focused Psychotherapy* (TFP) is another psychodynamic approach. TFP Assumes there is a psychological structure that underlies the specific symptoms of BPD. In such a psychological organization, thoughts and feelings about self and others are split into dichotomous experiences of good or bad, black or white, all or nothing. Since these either/or states determine the nature of the patient’s perceptions, *splitting* leads to chaotic interpersonal relations, impulsive self-destructive behaviours, and other symptoms of BPD. Splitting is a primitive defence mechanism in which the person externalizes internal conflicts by seeking to draw others around them into taking sides or being “good” or “bad”. Treatment – consisting of twice weekly individual psychotherapy sessions – focus on transference because it is believed that patients live out their predominant object relations dyads in the transference (Clarkin et al, 2007).

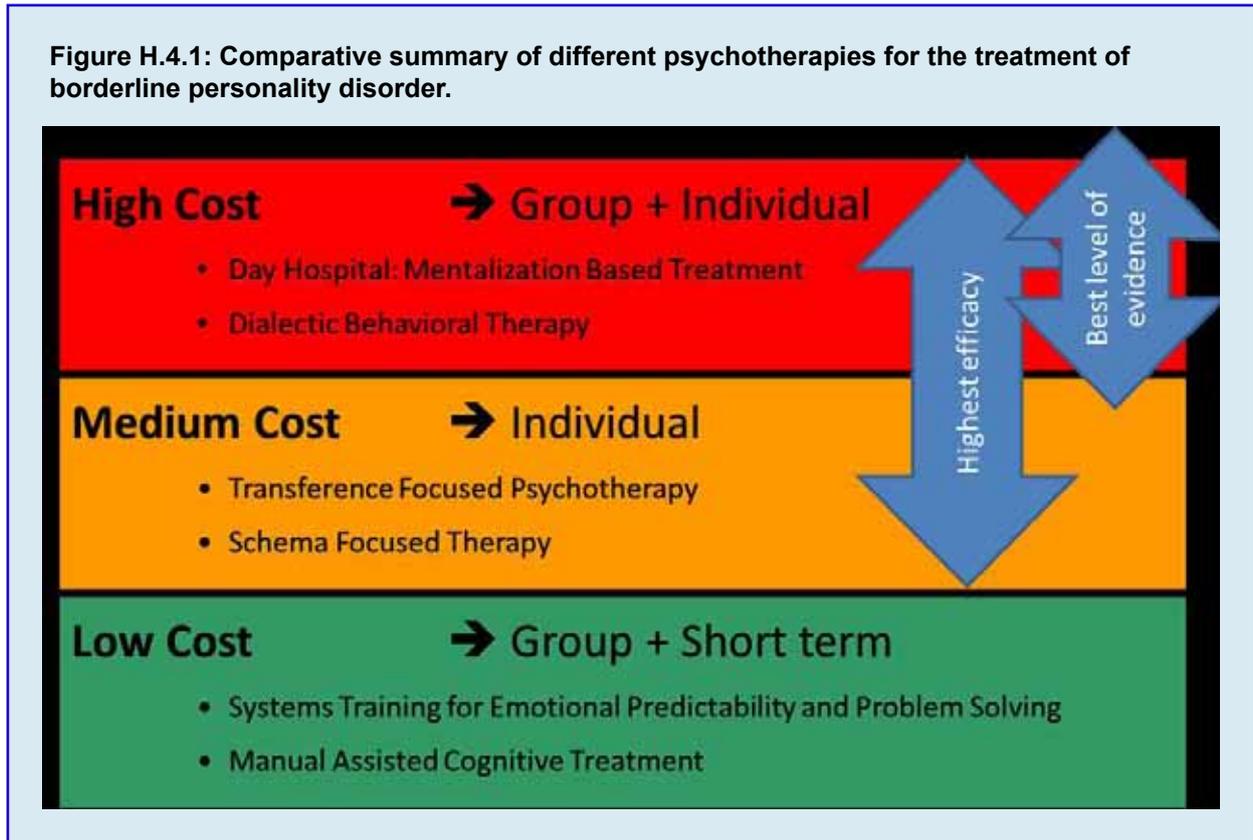
In adolescents, *Cognitive Analytic Therapy* (CAT; Ryle, 2004, Ryle & Beard, 1993) demonstrated similar efficacy to a “manualised good clinical care” treatment (Chanen et al, 2008). The CAT is a relatively brief treatment lasting from 16 to 24 sessions.

Among the *group treatments*, the Systems Training for Emotional Predictability and Problem Solving (STEPPS; Blum et al, 2002, Blum et al, 2008) is based on a systems approach. The program includes two stages: a 20-week basic skills group, and a one-year, twice monthly advanced group program. In this model,



Click on the picture to access a New York Times article on Marcia Linehan’s struggle with her BPD and the birth of Dialectical Behavior Therapy

**Figure H.4.1: Comparative summary of different psychotherapies for the treatment of borderline personality disorder.**



BPD is understood as a disorder of emotion and behaviour regulation. The goal is to provide persons with BPD, other professionals treating them and closely allied friends and family members with a common language to communicate clearly about the disorder and the skills used to manage it. This helps to avoid splitting.

It remains to be seen whether the gap between the number of treatments and their availability in clinical practice widens or narrows. Lack of support for these treatments at the front line may dishearten clinicians and lead them to ignore or reject psychotherapy options. It is important to remember at this point that a competently delivered treatment – meaning one that adheres to recommendations – seems to produce results that are as good as those obtained with more complex treatments (McMain, 2007).

### Other treatments

Many teams are working all over the world trying to develop shorter treatments that cost less and are more acceptable to patients than the traditional long term psychotherapeutic ones. Condensed forms of long-term treatment may be able to offer help to more patients. In the same vein, psycho-education and consumer groups may provide valuable alternatives at a lower cost. Setting up a permanent hotline to offer support in difficult times, perhaps at the level of a health region or even a country, may be useful. Finally, prevention services may develop strategies to help parents with a view to reducing the incidence of these disorders in children.



Click on the picture above to access the TARA website that provides information for sufferers and families (English). Click on the picture below to access a website that provides information in French.



## CONCLUSION

BPD is a disorder that can be found in adolescents; it has the range of symptoms and problems found in adults. However, in this age group BPD is even more changeable. A psychotherapeutic approach would result in a fast reduction of symptoms in many cases. The challenge is to identify the patients that are most at risk of developing severe disorders and offer them the most comprehensive care available.

---

## REFERENCES

- Abela JR, Skitch SA, Auerbach RP et al (2005). The impact of parental borderline personality disorder on vulnerability to depression in children of affectively ill parents. *Journal of Personality Disorders*, 19:68-83.
- American Psychiatric Association (1981). *Diagnostic and Statistical Manual of Mental Disorders*, third edition. Washington DC: American Psychiatric Association.
- American Psychiatric Association (1994). *Diagnostic and Statistical Manual of Mental Disorders* fourth edition, text revision. Washington DC: American Psychiatric Association.
- Bateman A, Fonagy P (1999). Effectiveness of partial hospitalization in the treatment of borderline personality disorder: a randomized controlled trial. *American Journal of Psychiatry*, 156:1563-1569.
- Bateman A, Fonagy P (2004). *Psychotherapy for Borderline Personality Disorder*. New York, NY: Oxford University Press.
- Bornovalova MA, Hicks BM, Iacono WG et al (2009). Stability, change, and heritability of borderline personality disorder traits from adolescence to adulthood: A longitudinal twin study. *Development and Psychopathology*, 21:1335-1353.
- Binks CA, Fenton M, McCarthy L et al (2006a). Pharmacological interventions for people with borderline personality disorder. *Cochrane Database of Systematic Reviews*, CD005653.
- Binks CA, Fenton M, McCarthy L et al (2006b). Psychological therapies for people with borderline personality disorder. *Cochrane Database of Systematic Reviews*, CD005652.
- Biskin R, Paris J, Renaud J et al. (2011). Outcomes in women diagnosed with borderline personality disorder in adolescence. *Journal of Canadian Academic Child Adolescent Psychiatry*, 20:168-174.
- Blum N, Pföhl B, John DS et al (2002). STEPPS: a cognitive-behavioral systems-based group treatment for outpatients with borderline personality disorder--a preliminary report. *Comprehensive Psychiatry*, 43:301-310.
- Blum N, St John D, Pföhl B et al (2008). Systems Training for Emotional Predictability and Problem Solving (STEPPS) for outpatients with borderline personality disorder: a randomized controlled trial and 1-year follow-up. *American Journal of Psychiatry*, 165:468-478.
- Bondurant H, Greenfield B, Tse T (2004). Construct validity of the adolescent borderline personality disorder: a review. *Canadian Child Adolescent Psychiatry Review*, 13:53-57.
- Bradley R, Jenei J, Westen D (2005). Etiology of borderline personality disorder: disentangling the contributions of intercorrelated antecedents. *Journal of Nervous and Mental Disease*, 193: 24-31.
- Cailhol L, Jeannot M, Rodgers R et al (in press). Borderline personality disorder and mental healthcare service use among adolescents. *Journal of Personality Disorders*.
- Chabrol H, Chouicha K, Montovany A et al (2001a). [Symptoms of DSM IV borderline personality disorder in a nonclinical population of adolescents: study of a series of 35 patients]. *Encephale*, 27:120-127.
- Chabrol H, Chouicha K, Montovany A et al (2002). [Personality disorders in a nonclinical sample of adolescents]. *Encephale*, 28:520-524.
- Chabrol H, Montovany A, Chouicha K et al (2001b). Frequency of borderline personality disorder in a sample of French high school students. *Canadian Journal of Psychiatry*, 46:847-849.
- Chanen AM, Jackson HJ, McCutcheon LK et al (2008). Early intervention for adolescents with borderline personality disorder using cognitive analytic therapy: randomised controlled trial. *British Journal of Psychiatry*, 193:477-484.
- Clarkin J, Yeomans F, Kernberg O (2006). *Psychotherapy for Borderline Personality*. Washington DC: American Psychiatric Publishing.

- Clarkin JF, Levy KN, Lenzenweger MF et al (2007). Evaluating three treatments for borderline personality disorder: A multiwave study. *American Journal of Psychiatry*, 164:922-928.
- Crawford TN, Cohen PR, Chen H et al (2009). Early maternal separation and the trajectory of borderline personality disorder symptoms. *Development and Psychopathology*, 21:1013-1030.
- Deschamps PK, Vreugdenhil C (2008). [Stability of borderline personality disorder from childhood to adulthood: a literature review]. *Tijdschrift voor Psychiatrie*, 50:33-41.
- First MB, Gibbon M, Spitzer RL et al (1997). *SCID-II Personality Questionnaire*. Washington, DC: American Psychiatric Press.
- Fruzzetti AE, Shenk C, Hoffman PD (2005). Family interaction and the development of borderline personality disorder: a transactional model. *Development and Psychopathology*, 17:1007-1030.
- Gerull F, Meares R, Stevenson J et al (2008). The beneficial effect on family life in treating borderline personality. *Psychiatry*, 71: 59-70.
- Gicquel L, Pham-Scottet A, Robin M et al (2011). [Etats limites à l'adolescence: diagnostic et clinique]. *Neuropsychiatrie de l'Enfance et de l'Adolescence*, 59:316-322.
- Giesen-Bloo J, Van Dyck R, Spinhoven P et al (2006). Outpatient psychotherapy for borderline personality disorder: randomized trial of schema-focused therapy vs transference-focused psychotherapy. *Archives of General Psychiatry*, 63:649-658.
- Golier JA, Yehuda R, Bierer LM et al (2003). The relationship of borderline personality disorder to posttraumatic stress disorder and traumatic events. *American Journal of Psychiatry*, 160:2018-2024.
- Goodman M, Patil U, Steffel L et al (2010). Treatment utilization by gender in patients with borderline personality disorder. *Journal of Psychiatric Practice*, 16:155-163.
- Grant B, Harford T, Dawson D et al (1995). The Alcohol Use Disorder and Associated Disabilities Interview Schedule (AUDADIS): reliability of alcohol and drug modules in a general population sample. *Drug and Alcohol Dependence*, 39:37-44.
- Gross R, Olfson M, Gameroff M et al. (2002). Borderline personality disorder in primary care. *Archives of Internal Medicine*, 162:53-60.
- Guedeney N, Lamas C, Bekhechi V et al (2008). [Attachment process between an infant and his/her mother: the first year]. *Archives de Pédiatrie*, 15 (sup 1):S12-S19.
- Gunderson JG (2001). *Borderline Personality Disorder: A Clinical Guide*, Washington, DC: American Psychiatric Publishing.
- Hobson RP, Patrick M, Crandell L et al (2005). Personal relatedness and attachment in infants of mothers with borderline personality disorder. *Development and Psychopathology*, 17:329-347.
- Hobson RP, Patrick M, Hobson JA et al (2009). How mothers with borderline personality disorder relate to their year-old infants. *British Journal of Psychiatry*, 195:325-330.
- Hoffman PD, Fruzzetti A, Buteau E et al (2005). Family connections: a program for relatives of persons with borderline personality disorder. *Family Process*, 44:217-225.
- Hyler SE, Rieder RO, Williams JB et al (1989). A comparison of clinical and self-report diagnoses of DSM-III personality disorders in 552 patients. *Comprehensive Psychiatry*, 30:170-178.
- Ingenhoven TJ, Duivenvoorden HJ (2011). Differential effectiveness of antipsychotics in borderline personality disorder: meta-analyses of placebo-controlled, randomized clinical trials on symptomatic outcome domains. *Journal of Clinical Psychopharmacology*, 31:489-496.
- Kernberg OF, Michels R (2009). Borderline personality disorder. *American Journal of Psychiatry*, 166:505-508.
- Korzekwa MI, Dell PF, Links PS et al (2008). Estimating the prevalence of borderline personality disorder in psychiatric outpatients using a two-phase procedure. *Comprehensive Psychiatry*, 49:380-386.
- Leischsenring F, Leibing E (2003). The effectiveness of psychodynamic therapy and cognitive behavior therapy in the treatment of personality disorders: A meta-analysis. *American Journal of Psychiatry*, 160:1223-1232.
- Leischsenring F, Leibing E, Kruse J et al (2011). Borderline personality disorder. *Lancet*, 377:74-84.
- Leung SW, Leung F (2009). Construct validity and prevalence rate of borderline personality disorder among Chinese adolescents. *Journal of Personality Disorders*, 23:494-513.
- Linehan MM, Armstrong HE, Suarez A et al. (1991). Cognitive-behavioral treatment of chronically parasuicidal borderline patients. *Archives of General Psychiatry*, 48:1060-1064.
- Livesley WJ (1998). Phenotypic and genetic structure of traits delineating personality disorder. *Archives of General Psychiatry*, 55:941-948.
- Loranger AW, Sartorius N, Andreoli A et al (1994). The International Personality Disorder Examination. The World Health Organization/Alcohol, Drug Abuse, and Mental Health Administration international pilot study of personality disorders. *Archives of General Psychiatry*, 51:215-224.
- Maffei C (2006). Personality disorders in Europe and USA: same diagnosis, different sights. In: VIIth European ISSPD Congress, June, Prague.

- McClellan J, Hamilton JD (2006). An evidence-based approach to an adolescent with emotional and behavioral dysregulation. *Journal of the American Academy of Child & Adolescent Psychiatry*, 45:489-493.
- McMain S (2007). Effectiveness of psychosocial treatments on suicidality in personality disorders. *Canadian Journal of Psychiatry*, 52 (sup):103S-114S.
- Mercer D (2007). Medications in the treatment of borderline personality disorder 2006. *Current Psychiatry Report*, 9:53-62.
- Miller AL, Muehlenkamp JJ, Jacobson CM (2008). Fact or fiction: Diagnosing borderline personality disorder in adolescents. *Clinical Psychology Review*, 28:969-981.
- National Institute for Health and Clinical Excellence (NICE) (2009). *Borderline Personality Disorder: Treatment and Management* [Online]. Available: <http://www.nice.org.uk/nicemedialive/12125/42900/42900.pdf>
- Newman LK, Stevenson CS, Bergman LR et al (2007). Borderline personality disorder, mother-infant interaction and parenting perceptions: preliminary findings. *Australian and New Zealand Journal of Psychiatry*, 41:598-605.
- Nose M, Cipriani A, Bianscosino B et al (2006). Efficacy of pharmacotherapy against core traits of borderline personality disorder: meta-analysis of randomized controlled trials. *International Clinical Psychopharmacology*, 21:345-353.
- O'Loughlin RE, Duberstein PR, Veazie PJ et al (2011). Role of the gender-linked norm of toughness in the decision to engage in treatment for depression. *Psychiatric Services*, 62:740-746.
- Paris J (2002). Chronic suicidality among patients with borderline personality disorder. *Psychiatric Services*, 53:738-742.
- Pascual JC, Malagon A, Corcoles D et al. (2008). Immigrants and borderline personality disorder at a psychiatric emergency service. *British Journal of Psychiatry*, 193:471-476.
- Pföhl B, Blum H, Zimmerman EA (1995). *Structured Interview for DSM-IV Personality Disorders (SIDP-IV)*. Iowa city: Department of Psychiatry, University of Iowa.
- Renou S, Hergueta T, Flament M et al (2004). [Structured diagnostic interviews in child and adolescent psychiatry]. *Encephale*, 30:122-134.
- Rinne T, Ingenhoven NT (2007). *Pharmacotherapy of Severe Personality Disorders: A Critical Review*. Cambridge: Cambridge University Press.
- Rossier J, Rigozzi C (2008). Personality disorders and the five-factor model among French speakers in Africa and Europe. *Canadian Journal of Psychiatry*, 53:534-544.
- Ryle A (2004). The contribution of cognitive analytic therapy to the treatment of borderline personality disorder. *Journal of Personality Disorders*, 18:3-35.
- Ryle A, Beard H (1993). The integrative effect of reformulation: Cognitive analytic therapy with a patient with borderline personality disorder. *British Journal of Medical Psychology*, 66:249-258.
- Sansone RA, Sansone LA, Wiederman MW (1996). Borderline personality disorder and health care utilization in a primary care setting. *Southern Medical Journal*, 89:1162-1165.
- Sansone RA, Gentile J, Markert R (2000a). Drug allergies among patients with borderline personality symptomatology. *General Hospital Psychiatry*, 22:289-290.
- Sansone RA, Songer DA, Gaither GA (2000b). Medically self-harming behavior and its relationship to borderline personality among psychiatric inpatients. *Journal of Nervous and Mental Disease*, 188:384-386.
- Sansone RA, Whitecar P, Meier BP et al (2001). The prevalence of borderline personality among primary care patients with chronic pain. *General Hospital Psychiatry*, 23:193-197.
- Shea MT, Stout R, Gunderson J et al (2002). Short-term diagnostic stability of schizotypal, borderline, avoidant, and obsessive-compulsive personality disorders. *American Journal of Psychiatry*, 159:2036-2041.
- Skodol AE, Gunderson JG, McGlashan TH et al (2002). Functional impairment in patients with schizotypal, borderline, avoidant, or obsessive-compulsive personality disorder. *American Journal of Psychiatry*, 159:276-283.
- Speranza M, Revah-Levy A, Cortese S et al (2011). ADHD in adolescents with borderline personality disorder. *BMC Psychiatry*, 11:158.
- Stangl D, Pföhl B, Zimmerman M et al (1985). A structured interview for the DSM-III personality disorders. A preliminary report. *Archives of General Psychiatry*, 42:591-596.
- Steele H, Siever L (2010). An attachment perspective on borderline personality disorder: Advances in gene-environment considerations. *Current Psychiatry Reports*, 12:61-67.
- Stoffers J, Vollm BA, Rucker G et al (2010). Pharmacological interventions for borderline personality disorder. *Cochrane Database of Systematic Reviews*, CD005653.
- Swartz MBD, George L, Winfiel I (1990). Estimating the prevalence of borderline personality disorder in the community. *Journal of Personality Disorders*, 4:257-272.
- Torgersen S (2001). The prevalence of personality disorders in a community sample. *Archives of General Psychiatry*, 58:590-596.
- Van Asselt AD, Dirksen CD, Arntz A et al (2007). The cost of borderline personality disorder: Societal

- cost of illness in BPD-patients. *European Journal of Psychiatry*, 22:354-361.
- Wong HM, Leung HC, Chow LY et al (2010). Prevalence of borderline personality disorder and its clinical correlates in Chinese patients with recent deliberate self-harm. *Journal of Personality Disorders*, 24:800-811.
- World Health Organization (2000). *International Classification of Diseases and Related Health Problems*. Geneva: World Health Organization.
- Young JE (1999). *Cognitive Therapy for Personality Disorders: A Schema-Focused Approach*. Sarasota, FL: Professional Resource Press.
- Zanarini MC, Gunderson JG, Frankenburg FR et al (1990). Discriminating borderline personality disorder from other axis II disorders. *American Journal of Psychiatry*, 147:161-167.
- Zanarini MC, Williams AA, Lewis RE et al (1997). Reported pathological childhood experiences associated with the development of borderline personality disorder. *American Journal of Psychiatry*, 154:1101-1116.
- Zanarini MC, Frankenburg FR, Dubo E et al (1998a). Axis I comorbidity of borderline personality disorder. *American Journal of Psychiatry*, 155:1733-1739.
- Zanarini MC, Frankenburg FR, Dubo ED et al (1998b). Axis II comorbidity of borderline personality disorder. *Comprehensive Psychiatry*, 39 :296-302.
- Zanarini MC, Frankenburg FR, Hennen J et al (2003a). The longitudinal course of borderline psychopathology: 6-year prospective follow-up of the phenomenology of borderline personality disorder. *American Journal of Psychiatry*, 160:274-283.
- Zanarini MC, Vujanovic AA, Parachini EA et al (2003b). A screening measure for BPD: The McLean Screening Instrument for Borderline Personality Disorder (MSI-BPD). *Journal of Personality Disorders*, 17:568-573.
- Zanarini MC, Frankenburg FR, Hennen J et al (2005). Psychosocial functioning of borderline patients and axis II comparison subjects followed prospectively for six years. *Journal of Personality Disorders*, 19:19-29.
- Zanarini MC, Frankenburg FR, Hennen J et al (2006). Prediction of the 10-year course of borderline personality disorder. *American Journal of Psychiatry*, 163:827-832.
- Zanarini MC, Frankenburg FR, Reich DB et al. (2007). The subsyndromal phenomenology of borderline personality disorder: a 10-year follow-up study. *American Journal of Psychiatry*, 164:929-935.
- Zittel Conklin C, Westen D (2005). Borderline personality disorder in clinical practice. *American Journal of Psychiatry*, 162:867-875.
-