TREATMENT

Evidence and opinion continue to support the recommendation of the 2001 guideline that psychotherapy represents the primary, or core, treatment for this disorder and that adjunctive, symptom-targeted pharmacotherapy can be helpful. For personality disorders in general, studies of psychotherapy report its effectiveness (56, 57). Persuasive data from randomized, controlled trials (RCTs) of BPD suggest that more than one type of psychotherapy is effective, and additional studies are under way. Dialectical behavior therapy (DBT) has been shown in an RCT to be effective for borderline symptoms in patients with comorbid BPD and substance abuse, though no improvement was shown for the substance abuse itself (58). In another RCT, in patients with BPD and comorbid opiate use, DBT was compared with comprehensive validation therapy (CVT). Both types of treatment were effective. There were fewer dropouts in the CVT group, and the maintenance of gains was greater in the DBT group (59). Studies of DBT by diverse research groups are being published, including a study of female veterans with BPD that compared 6 months of DBT with treatment as usual and reported improvement in the DBT group compared with the control group (60). Another study from the Netherlands that compared 12 months of outpatient DBT with treatment as usual showed better treatment retention, reduced self-mutilation, and reduced self-damaging impulsivity in the DBT group (61). An intriguing inpatient RCT that compared 3 months of inpatient DBT with treatment as usual in the community demonstrated significant gains in the DBT group compared with the control group, including reduced self-injury, dissociation, depression, and anxiety, and improved interpersonal functioning and social adjustment (62).

Promising new psychotherapies for BPD are being piloted in open trials. These include interpersonal therapy (63); cognitive therapy (64); cognitive analytic therapy (CAT), a fusion of cognitive and psychodynamic therapy (65, 66); and systems training for emotional predictability and problem solving (STEPPS), a cognitive-behavioral systems–based form of time-limited group treatment for patients with BPD (67). In an ongoing study comparing transference-focused psychotherapy (TFP) with DBT and supportive psychotherapy, TFP appeared to be beneficial (68), although the comparative analysis of the other two treatments has yet to be completed. The efficacy of TFP is also being assessed in a large multicenter study comparing TFP with schema therapy for patients with BPD (69).

A number of recent studies have focused on the benefits of pharmacotherapy for patients with BPD. An RCT that compared patients receiving fluvoxamine with a control group showed robust, long-lasting reduction in rapid mood shifts only in the treatment group (70). Another RCT that compared olanzapine with placebo in borderline patients showed improvement in global functioning in the medication group compared with the placebo group (71). Another RCT studied three groups of BPD patients—one group receiving fluoxetine, a second group receiving olanzapine, and a third receiving a combination of both; all three interventions led to substantial improvement, though a significantly greater rate of improvement in clinician-rated depression and impulsive aggression was seen in the olanzapine and the combination groups (72). Also, double-blind, placebo-controlled trials demonstrated benefit of divalproex sodium for patients with BPD (73) and for patients with cluster B personality disorders who demonstrate impulsive aggression (74). A number of case reports and noncontrolled medication trials have also been published (75–81).

All in all, the database is growing, and further evidence is accumulating that BPD is a condition that can be effectively treated by a combination of psychotherapy and symptom-targeted pharmacotherapy. Further
research is needed to validate the approach taken by the 2001 guideline to select one of three different medication algorithms on the basis of the predominance of cognitive-perceptual symptoms, affective dysregulation symptoms, or impulse dyscontrol symptoms. One retrospective report from the NIMH Collaborative Longitudinal Personality Disorders Study produced mixed results on this question (82).