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The Role of Pharmacotherapy and Psychotherapy in Borderline Personality Disorder - a literature review

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Abstract

Borderline personality disorder (BPD) is a severe and heterogeneous psychiatric disorder known to begin at a young age, often in adolescence. It is associated with suicidal behaviour and self-harm. Up to 10 per cent of BPD patients die by suicide, so it is very important to find effective methods to alleviate the symptoms of this disorder [1]. A combination of psychotherapy and pharmacotherapy seems reasonable. An obstacle to widespread access to psychotherapy is the relatively high costs associated with the salaries of highly qualified psychotherapists. Another impediment is the long time required for effective psychotherapy and the frequent phenomenon of patients with unstable emotions discontinuing therapy prematurely. On the other hand, pharmacotherapy is necessary during periods of aggravation of the disorder, such as increased emotional lability, dysphoric states associated with aggression, impulsive behaviour and the presence of pseudopsychotic symptoms. This paper is a compilation of available treatments for borderline disorder. In the context of considering effective therapies for BPD, an important aspect is the need to increase the length of therapy and the availability of professional help for patients. In addition, research points to the benefits of combining psychotherapy with pharmacotherapy to more effectively alleviate the symptoms of this heterogeneous disorder. It is noteworthy that the relatively high cost of psychotherapy and the need to decrease.

Keywords: borderline personality disorder (BPD), psychotherapy, pharmacotherapy

Introduction

There are a number of aspects for which borderline personality disorder is problematic from a clinical perspective. Firstly, people with this disorder experience very intense and often conflicting emotions, leading to a sense of distress and a constant risk of self-harm or death. In addition, the treatment of patients with this disorder is difficult and the effectiveness of treatment is a considerable challenge. It is also worth mentioning that, despite its long existence and numerous changes in diagnostic criteria, the current form of this category of disorder is fairly new and may seem somewhat fuzzy.

Borderline personality disorder is characterized by an uncertain and shifting sense of identity, turbulent interpersonal relationships, as well as impulsive behavior, periodic outbursts of anger and a persistent sense of emptiness. In some patients it is also combined with suicidal

tendencies and behaviour, self-harm, as well as paranoid delusions and severe dissociative symptoms. All personality disorders bring many diagnostic and therapeutic problems. Borderline personality disorder is a psychiatric disorder with a heavy burden on patients, family members and health care systems. Previous classifications of BPD have been mainly based on typology. . Typically, the different types of personality disorder are defined by about eight characteristics, five of which are necessary for diagnosis. This way of categorising means that the criteria for the same disorder can be met in different ways. For borderline personality disorder, for example, there are more than 200 possible combinations of criteria fulfilment, which means that there is a great deal of variation within this group - people with the same diagnosis may have different combinations of traits [2]. Both DSM-V and ICD-11 have changed the approach to diagnosing personality disorders. They are now based on a dimensional model, in which the difference between healthy and disordered personality is only quantitative. Psychodynamic diagnostic practices have also been adopted. The new classification considers three levels of disorder - mild, moderate and profound. The term 'personality problems' can also be used in the context of the subclinical occurrence of disorder symptoms[3].In recent years, there have been a lot of contradictory positions regarding the combination of pharmacotherapy and psychotherapy (in the broad sense of different types of mental disorders). While the majority of clinicians are in favour of combining the two therapies, there are also many arguments against this practice. Arguments against include the following: the use of medication may reduce symptoms and, as a result, reduce the willingness to understand existing problems and to make necessary changes; the rapid improvement in well-being following medication may reinforce the tendency for immediate gratification and thus weaken the commitment to therapy, which, once symptoms are relieved, may be perceived as merely unpleasant.

Additionally, the disappearance of symptoms after medication does not automatically mean the disappearance of the disorder itself. Pharmacotherapy works by inhibiting the symptoms of the disorder rather than completely remitting them. Patients often do not realise this and interpret the disappearance of symptoms as a full recovery, leading to obvious complications. The arguments for combining psycho- and pharmacotherapy are also numerous. Pharmacotherapy can improve concentration and also reduces distorted or irrational thinking to some extent, reinforcing the positive effects of psychotherapy. Medication reduces agitation, aggression and anxiety, which promotes the benefits of therapy. Psychotherapy in turn improves adherence to pharmacotherapy. Medication can facilitate the use of

psychotherapy and life changes in depressed patients, affecting their functioning. The combination of psychotherapy and pharmacotherapy can also lead to resolution of somatic abnormalities. For patients with concomitant severe illnesses, integrated treatment has been shown to be more effective [4]. Due to the multiplicity of symptoms and comorbid disorders in patients with BPD, both clinicians and therapists should take an integrated approach to treatment.The main clinical guidelines for the treatment of borderline personality disorder recommend psychotherapy as first-line treatment [3].

Pharmacotherapy

Borderline Personality Disorder (BPD) is a mental health condition characterized by instability in mood, self-image, and interpersonal relationships. While psychotherapy is considered the primary treatment for BPD, pharmacotherapy can be a helpful adjunct in managing specific symptoms or co-occurring conditions. It's important to note that medication should be prescribed and monitored by a qualified mental health professional, such as a psychiatrist. Here are some commonly used medications in the pharmacotherapy of Borderline Personality Disorder:

Antidepressants:

Selective Serotonin Reuptake Inhibitors (SSRIs): Medications like fluoxetine, sertraline, and paroxetine may be prescribed to help alleviate symptoms such as depression, anxiety, and mood swings.

Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs): Venlafaxine is an example of an SNRI that may be used to address mood and anxiety symptoms.

Mood Stabilizers:

Lamotrigine: This anticonvulsant is sometimes used to stabilize mood and reduce impulsivity in individuals with BPD.

Valproate: Another mood stabilizer that may be considered in certain cases.

Antipsychotics:

Aripiprazole, Olanzapine, Quetiapine: Atypical antipsychotics may be prescribed to address mood instability, anger, and impulsivity.

Anxiolytics:

Benzodiazepines (e.g., Clonazepam): These may be used on a short-term basis to manage severe anxiety or agitation. However, caution is needed due to the risk of dependence.

It's important to recognize that while medication can be helpful, it is not a cure for BPD. Medications may target specific symptoms associated with the disorder, but they do not address the core issues underlying BPD. Psychotherapy, particularly Dialectical Behavior Therapy (DBT), is considered the gold standard for treating BPD.

Additionally, medication management should be individualized, and potential risks and benefits should be carefully considered. Regular monitoring and communication between the individual and their mental health provider are crucial to assess the effectiveness of the medication and make any necessary adjustments. It's also important for individuals with BPD to engage in a comprehensive treatment plan that may include therapy, support groups, and lifestyle changes.

The realistic goal of pharmacotherapy is not to 'cure' the patient, as medication does not change the temperament, but by design can reduce or alleviate symptoms, which is important for chronic borderline personality disorder. The pharmacotherapeutic plan should not cover the whole personality, but focus only on the behavioural aspects. Special attention should be paid to the treatment of affective dysregulation and impulsivity and aggression, as they significantly increase the risk of self-harming and suicidal behaviour [5]. The frequent occurrence of mood disorders (depressive episodes, prolonged dysthymic symptoms) in people with BPD has led to antidepressants being used as primary pharmacotherapy. According to research, serotonin reuptake inhibitors (SSRIs) should be the first-line

medication - they are particularly recommended for high aggression, impulsivity and emotional vacillation

However, this recommendation, based on the results of 10 open-label trials of BPD patients with SSSRIs, are inconclusive due to the large placebo response [6].

Currently, the pharmacological approach, supported by some experimental results, follows the so-called 'dimensional' standard.

The targets of this standard pharmacological approach are specific psychopathological 'dimensions' of the disorder and associated neurotransmitter changes, in particular those related to the serotonergic and dopaminergic systems, both supported by experimental results. The psychopathological dimensions to which a pharmacological approach is appropriate are impulsivity and emotional dysregulation. In recent years, the efficacy of atypical antipsychotics has become a major focus of interest in the treatment of borderline disorders, mainly related to their effects specifically on the serotonergic and dopaminergic systems[7]. In their review, Jutta Stoffers-Winterling, Ole Jakob Storebø & Klaus Lieb drew on recent evidence from randomised controlled trials evaluating the continuation of pharmacological treatment in people diagnosed with BPD. The authors noted that there is a clear gap between the available evidence and practice [8]. To enable people with BPD and clinicians to make informed decisions, we need more randomised controlled clinical trials (RCTs). On the one hand, these studies should replicate previous positive results that have already appeared in trials. On the other hand, there is a need for more specific studies that focus on patients with various comorbidities, especially depression (when pharmacotherapy, especially SSRIs, is required). For interventions, we need more RCTs that evaluate the efficacy of commonly used drugs such as SSRIs and second-generation antipsychotics. Additionally, new research does not support the efficacy of fluoxetine as a treatment for suicide and self-harm prevention. A large study did not show a beneficial effect of lamotrigine in routine care. The use of common medications in BPD is still not confirmed or supported by the current evidence, this is also demonstrated by the 2021 meta-analysis by Gerald Gartlehner and colleagues [9]. Jutta M Stoffers-Winterling et al. in their meta-analysis, they point out that more research is also needed on comorbidities such as trauma-related disorders, major depression, substance use disorders or eating disorders. Furthermore, greater emphasis should be placed on samples of men and adolescents [10].

Psychotherapy

Despite reports that spontaneous improvement occurs in some people (approximately 4%/year), it is estimated that psychotherapy accelerates improvement several times [11].

Psychotherapy is considered the primary and most effective treatment for Borderline Personality Disorder (BPD). Various therapeutic approaches have shown positive outcomes, but one of the most well-researched and widely used interventions for BPD is Dialectical Behavior Therapy (DBT). However, other therapeutic modalities can also be beneficial. Here are some psychotherapeutic approaches commonly used in the treatment of Borderline Personality Disorder:

Dialectical Behavior Therapy (DBT):

Developed by Dr. Marsha Linehan, DBT is a comprehensive and evidence-based treatment for BPD. It combines cognitive-behavioral techniques with mindfulness strategies. DBT focuses on helping individuals regulate their emotions, improve interpersonal effectiveness, tolerate distress, and develop skills for mindful living.

Cognitive-Behavioral Therapy (CBT):

Traditional CBT helps individuals identify and change maladaptive thought patterns and behaviors. While not as specifically designed for BPD as DBT, CBT can be beneficial in addressing distorted thinking, impulsivity, and emotional dysregulation.

Schema-Focused Therapy:

This therapeutic approach targets underlying maladaptive schemas or core beliefs that contribute to BPD symptoms. It aims to identify and modify these deep-seated patterns of thinking and behaving.

Psychodynamic Psychotherapy:

Psychodynamic approaches explore unconscious conflicts and early life experiences that may contribute to BPD symptoms. The therapeutic relationship is a central focus, and the goal is to bring awareness to unconscious processes and patterns.

Transference-Focused Psychotherapy (TFP):

TFP is a specialized form of psychodynamic psychotherapy designed for individuals with personality disorders, including BPD. It focuses on understanding and working with the transference and countertransference dynamics in the therapeutic relationship.

Mindfulness-Based Therapies:

Mindfulness practices, such as those derived from Buddhist traditions, can be integrated into therapy to help individuals develop awareness and acceptance of their emotions without judgment. Mindfulness-Based Cognitive Therapy (MBCT) may also be used.

Interpersonal Therapy (IPT):

IPT focuses on improving interpersonal relationships and addressing communication and relational issues. It can be beneficial for individuals with BPD who struggle with relationship instability.

Mentalization-Based Therapy (MBT):

MBT emphasizes the development of mentalizing skills, which involve understanding one's own and others' thoughts, feelings, and intentions. This can enhance interpersonal functioning.

It's important to note that the therapeutic relationship plays a crucial role in the success of any psychotherapeutic approach for BPD. Tailoring the treatment to the individual's specific needs and preferences is key. In many cases, a combination of different therapeutic approaches may be used to address the complexity of Borderline Personality Disorder.

Research reports relating to the effectiveness of therapy concern primarily therapies belonging to the cognitive-behavioral and psychodynamic/psychoanalytic approaches. The first approach includes Marsha Lienhan's dialectical-behavioral therapy and schema therapy. The second approach is mentalization-based therapy and transference-oriented therapy.

A 2020 analysis of the effectiveness of classic cognitive-behavioral therapy and dialectical behavioral therapy (adapted to the needs of people with borderline personality disorder)

showed that they have a significant impact on the social functioning of people with BPD. A meta-analysis of 880 patients showed that therapies tailored to borderline disorder improve social functioning compared to standard therapies. These results are consistent with an analysis conducted in 2017, which also showed the significant effectiveness of dialectical behavioral therapy (DBT) in reducing symptoms such as self-harm and suicide attempts[12].

To treat the complex and varied symptom picture associated with the presence of emotional dysregulation, DBT uses a number of strategies aimed at creating a synthesis and balance between acceptance and change. This means that the intervention is based on change-oriented cognitive-behavioral assumptions and strategiesthoughts, feelings/emotions and dysfunctional behaviors, but also on interventions based on Mindfulness, which are oriented towards self-acceptance [13].Research by Chakhssi et al. from 2021, also confirm that both dialectical behavioral therapy and other therapeutic approaches improve the quality of life of patients with borderline disorder compared to control conditions.Despite this evidence for the effectiveness of cognitive-behavioral therapy in the treatment of personality disorders, there is still a lack of data on the long-term effects of psychotherapy [14]. Another cognitive-behavioral therapy is schema therapy.Schema therapy was developed in 1994 by Young.Young and his colleagues realized that some patients did not benefit from standard cognitive-behavioral approaches.

They discovered that that these people had recurring and persistent patterns or themes thoughts, emotions and behaviors that required new intervention tools. New intervention tools. People from personality disorders have developed maladaptive patterns and, as a result, they cope with their lives worse. The primary sources of the most serious personality disorders, according to schema therapy, are unmet emotional needs from childhood, in particular those related to rejection, or emotions related to physical abuse/violence [13].Therapies are listed on the website of the American Psychological Association's 12th Working Group considered effective, potentially effective or controversial, according to the guidelines Tolina et al. (2015). Researchers report 4 types of therapies mentioned earlier. Dialectical behavioral therapy has been found to be well documented and strongly supported. Young's schema therapy and mentalization-based therapy were considered likely to be effective. However, further research is required regarding the effectiveness of psychotherapy focused on the Kernberg transference [15]. Mentalization is the ability to understand observed actions, both our own and those of others, in the context of the hidden mental processes that influence them.

Difficult experiences during development that lead to personality disorders weaken the ability to mentalize, especially in close relationships. To improve mental health and social functioning, therapy can focus on improving the ability to mentalize in people with BPD [16].

The least documented therapy in terms of effectiveness is transference-based therapy.

Transference-focused therapy (TFP) is a form of psychodynamic therapy based on Otto F. Kernberg's object relations model. It aims to resolve contradictions in internal representations of self and others that are emotionally charged. People with borderline personality disorder have difficulty establishing healthy relationships with others and themselves. Therapy focuses on integrating these personality contradictions and other people's representations, and the interpretation of distorted perceptions plays an important role in the change process. Distorted perceptions of oneself, others and related emotions are the subject of treatment because they appear in the relationship with the therapist (transference) [17].

The therapy plan should be discussed together with the patient. The therapist, depending on his or her training, should propose a therapy method whose effectiveness in the treatment of BPD has been confirmed (the 4 types of therapy mentioned earlier). It is worth talking to the patient about the therapist's suggested method or the method in which the therapist is trained, so that the patient can also learn about alternative approaches and make a choice.

Regardless of the choice of therapy, it should meet the following conditions:long-term, several-year nature of treatment; focusing on a specific area (e.g. self-harm, patterns of interpersonal relationships, aggression); efforts to improve cooperation, compliance with recommendations, and attention to theoretical coherence; active validation of the patient's emotions and support. The focus should be on providing the patient with the ability to regulate emotions and cope with impulsivity, which is preferable to focusing on analyzing past experiences. The therapist should be directive, active, authentic and committed. Focusing on key issues related to borderline personality disorders, such as emotional dysregulation, impulsivity, cognitive impairment and relationship difficulties, will form the basis of therapy goals and a reference point for assessing its effectiveness

Summary

The combination of psychotherapy and pharmacotherapy reduces the risk of relapse, supports the patient's ability to use healthy coping strategies, increases compliance, and enables a focus on integration rather than splitting in the case of disorders such as borderline personality disorder [5] .

Unfortunately, there is often a delay in the diagnosis and treatment of borderline personality disorder because some symptoms are underestimated and clinicians are reluctant to diagnose BPD in younger people. In this age group, there is stigmatization, incomplete personality development, and the similarity of BPD symptoms to physiological changes typical of adolescence, which causes resistance to diagnosis. However, early identification of BPD symptoms can lead to early intervention programs that provide appropriate treatment [18].

There are no clear recommendations regarding the sequence of psychotherapeutic and pharmacological therapy. The decision on simultaneous application or a specific order is difficult to determine. Often, patients who participate in psychotherapy are additionally referred to pharmacotherapy if there is no improvement or to enhance the effects. In other cases, patients are referred to psychotherapy after controlling the main clinical symptoms, such as acute anxiety, psychotic experiences or significant mood changes [4].

When talking about combining therapies, it is also worth paying attention to the fact that people with borderline personality disorders suffer from multiple medications. Although longer-term and more detailed psychotherapies are known to be effective, they are not readily available. Therapy takes time and is expensive in terms of human resources. The easiest choice for clinicians and patients is to focus on drug treatment of individual symptoms rather than the personality disorder as a whole. The current situation in which patients with severe personality disorders receive almost routine polypharmacy is unsatisfactory. The only way to change this situation is to increase the availability of specialized psychotherapy [20].

Research conducted over the last two decades has clearly demonstrated that the effectiveness of BPD therapy improves over time, and patients have greater opportunities to choose treatment methods [21]. Although BPD is associated with many bothersome symptoms that impact the patient's work and social life, many of these symptoms improve within the first few years of treatment. Unfortunately, some core personality traits persist for a long time and are not fully addressed by current treatments. Specialized psychotherapy is intended to help

patients with BPD, but long-term recovery and return to full functionality is a challenge [22]. One potential solution is to identify patients with BPD earlier. Early intervention can enable these patients to achieve a healthier life path at an early stage and achieve satisfactory social and professional functioning, which is often difficult for older patients. Further improvement of treatments for the younger population may lead to greater changes in the long-term course of BPD.

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