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Borderline personality disorder and unmet needs

Ales Grambal [1], Jan Prasko [1], Marie Ociskova [1], Milos Slepecky [2], Antonia Kotianova [2], Zuzana Sedlackova [3], Marta Zatkova [2], Petra Kasalova [1], Dana Kamaradova [1]

1 Department of Psychiatry, University Hospital Olomouc, Faculty of Medicine, Palacky University in Olomouc, Czech Republic
2 Department of Psychology Sciences, Faculty of Social Science and Health Care, Constantine the Philosopher University in Nitra, the Slovak Republic
3 Department of Psychology, Faculty of Arts, Palacky University Olomouc, Czech Republic

Correspondence to: Jan Prasko
Department of Psychiatry, Faculty of Medicine and Dentistry,
Palacky University Olomouc, University Hospital
I. P. Pavlova 6, 77520 Olomouc, Czech Republic.
TEL: + 420 588 443 503; E-MAIL: praskojan@seznam.cz

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Abstract

BACKGROUND: Borderline personality disorder (BPD) is a disabling psychiatric condition with a chronic and challenging course. BPD is reflected as a disorder of self-regulation" and is associated with both psychological vulnerabilities and social relations that fail to support basic emotional needs. The objective of the paper is to provide the up-to-date data on the unmet needs of BPD patients and their families.
METHOD: A computerized search of the literature printed between January 1990 and May 2017 was conducted in PubMed, and additional papers were extracted using keywords "borderline personality disorder,"needs," "pharmacotherapy," "psychotherapy," "CBT," and "family" in various combinations. According to the eligibility criteria, 57 articles were chosen. Secondary articles from the reference lists of primarily identified papers have been selected for the eligibility and added to the first list (N=151).
RESULTS: The results were divided into three categories: the needs connected with (1) the symptom control; (2) the treatment; (3) the quality of life. The needs connected with symptoms were described issues such as emotional needs, social interactions, self-harm, parasuicide, suicidality, comorbidity, mentalization, identity disturbance, moreover, barriers to treatment. The needs connected with the treatment described are focused on needs for early diagnosis, early intervention, holding environment, therapeutic relation, assertive community treatment, destigmatization, hospitalization, and primary care. The needs connected with the quality of life involve family needs, physical health, spiritual needs, advocacy needs, and needs for the separation-individuation. The part focused on implications for the treatment presented several treatment approaches, focusing mostly on the their basics and efficacy.
CONCLUSION: Observing the patients' needs may be essential to the treatment of the individuals suffering from BPD. However, many needs remain unmet in the areas linked to medical, personal, and social factors. A bigger focus on the patients' needs could be beneficial and should be targeted in the treatment.

ORIGINAL ARTICLE

INTRODUCTION

Borderline personality disorder (BPD) characterizes disinhibition and impulsivity, emotion dysregulation, risk-taking behavior, fear of abandonment, feelings of emptiness, irritability, and self-injury, as well as unstable interpersonal relationships (Ryan 2005, APA 2013). Most features of borderline pathology can be divided into three dimensions: disturbed affect regulation, identity disturbance, and problems in social interaction (Linehan 1993a; Bohus & Kröger 2011; Dimaggio *et al.* 2013). The prevalence of the disorder in the general population lies between 2% and 6%, with 75% of those suffering being women (APA 2013). However, some investigators report the same prevalence rates between the sexes (Grant *et al.* 2008). The development of the disorder relates to specific nature and nurture factors (Ryan 2005; Paris 2009; APA 2013). A common theme in the histories from a childhood of BPD patients is repetitive trauma (e.g., sexual, physical, or emotional abuse or witnessing domestic violence) (Sauer *et al.* 2014; Sansone & Sansone 2015; Weibel *et al.* 2017). Linehan (1993) supposed that the main problem in BPD is emotional dysregulation as a result of a genetic tendency to overemotionality and invalidating environment during personal development. Several recent studies also recognized that neuropsychological dysfunction of BPD affects domains such as attention, cognitive flexibility, memory, planning, processing speed and visuospatial skills (Ruocco 2005; Le Gris *et al.* 2006; Dell' Oso *et al.* 2010; Fertuck *et al.* 2012; Mark & Lam 2013). Accordingly neuroimaging studies reported structural and functional abnormalities in various brain areas supporting the assumption of a dysfunctional fronto-limbic network in subjects with BPD (Nunes *et al.* 2009; Wingenfeld *et al.* 2010; Leichsenring *et al.* 2011; Ruocco *et al.* 2012; Niedtfeld *et al.* 2013; Salvador *et al.* 2016; Soloff *et al.* 2015).

In the last decades, a growing attention to human rights and stressing the sensibility to autonomy has given a requirement to the encourage of the users of psychiatric care. Patients started to recognize their needs and focused more on their health and social care utilization. The traditional paternalistic physician–patient relationship is changed by authorizing the patients and their families. The discussion has concentrated on the necessity for freedom and respect, and the existential appeals, such as the need to experience a meaningful life. The aim of this paper is to explore recent scientific information regarding the needs of the patients suffering from BPD by reviewing and summarizing the published facts about the topic and show the broad concept of patients' needs.

METHOD

The PubMed database was used to search for papers published from January 1990 to May 2017 by using the following terms: „borderline personality disorder" and "needs" in successive combination with "pharmacotherapy", "psychotherapy", "dialectical behavioral therapy", "schema therapy" "cognitive behavioral therapy", "transference focus therapy" "family", "quality of life", "emotionally unstable", or "physical health". The used filters were: humans and adults (19 + years). Furthermore, the included studies had to meet the criteria for inclusion (1) published in peer-reviewed journals; (2) the articles could have been prospective or retrospective original studies in humans; or (3) reviews on the relevant topic; (4) the papers were published in English. The criteria for exclusion were (1) conference abstracts; (2) commentaries and dissertations. We utilized a flow diagram to summarize the total number of screened papers and the number of those included in the review process as suggested by the PRISMA Guidelines (Moher *et al.* 2009) (Figure 1).

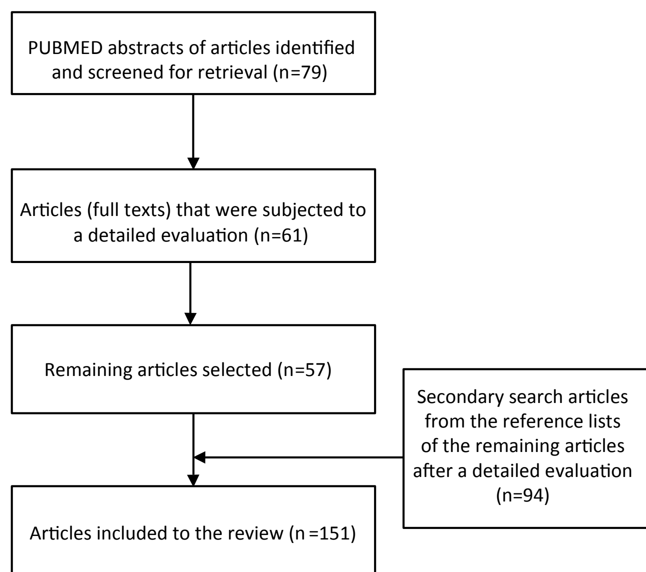

Fig. 1. Summary of the selection process.

RESULTS

Three distinct group of categories were formed after discussion of authors which categories of needs fit the best to the aim of the study: needs connected (1) with the symptoms; (2) with the treatment; and (3) with the quality of life. Within these groups of categories, we described many classes of needs, which presented a significant problem in the patients´ life.

Needs connected with the symptoms

The patients may express fears about durable symptoms and have difficulties in handling them (Akhtar 1998; Dimaggio *et al.* 2013). They are often related to the lack of emotional control, insight, information, and support from family or the medical staff (Sansone *et al.* 1998; Schimmel 1999; Shanks *et al.* 2011). Symptoms may

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suppress some needs or potentiate others, depending on the stage of the disorder (Ryan 2005; Zimmerman 2016). The needs related to the symptom control can be more noticeable in several distinct subcategories: emotional needs, needs for social interaction, needs connecting with the deliberate self-harm and parasuicides, suicidality, needs related to comorbidity, lack of mentalization, and identity disturbance.

Emotional needs

Zanarini *et al.* (1997) point out that people with BPD meet in childhood with emotional, physical and sexual abuse. They are often put in the role of a parent (reversed role), lacking sufficient protection, no one notices their feelings (Herman *et al.* 1989, Westen *et al.* 1990). A typical threatening environment is associated with unpredictability and propensity in parental behavior when the child is unable to understand and predict the occurrence or severity of punishments (Ogata *et al.* 1990, Ménard and Pincus 2014, Waxman *et al.* 2014). An invalidating environment in childhood, which did not responds properly on the expression of private child experience (beliefs, thoughts, feelings, sensations) is essential for *no fulfilling the basic emotional needs* for safety, love, encouragement, respect and autonomy (Linehan 1993a; Lobbestael & Arntz 2010; Bohus & Kröger 2011). Also prolonged and severe trauma, most importantly the trauma that occurs early in the life, can lead to future *failures in control of the emotions* (van der Kolk *et al.* 1994; Terzi *et al.* 2017). From other issues autonomy is discussed as a developmental route that is reliant on the concrete supports from important persons (Young 1994). Because of previous experiences, many patients are unable to speak about their needs or do it inappropriate way. Some of these attempts include clinging and unselective relations with others in which old traumas are eventually re-enacted over time (Bouchard *et al.* 2009; Dimaggio *et al.* 2013; Leppänen *et al.* 2016). Others present more self-directed behaviors such as eating disorders, self-mutilation, and substance abuse (Gratz & Tull 2011; Hawton *et al.* 2016). Frequently, the patients use more of these dysfunctional strategies. When the strategies fail, self-destructive behavior or suicide attempts often take place (Holm & Severinsson 2008). During the treatment of people with BPD, therapists can expect that painful emotions related to the emotional and interpersonal needs may escalate to dissociative episodes (van der Kolk *et al.* 1994; Lobbestael & Arntz 2010).

The therapy has to make clear how up-to-date stresses are experienced as a reappearance of the traumas from past and how minor troubles in current relations can be seen as a reappearance of previous abandonment (Young 1994). It is important that the therapist delivers support, acceptance, validation of the individual´s experience, and the refinement of more mindful and reflective regulation of actions (Clarkin *et al.* 2004; Young 1994; Verheul *et al.* 2003).

Social interactions

Expectations of malevolence, persistent feelings of bitterness and anger, along with a disrupted ability to regulate emotions, can contribute to maintaining intense, hostile and unstable relationships (Stone 2001; Chapman & Linehan 2005). The interpersonal style is characterized by the need for closeness fluctuating to emotional distancing, unstable relatedness, intense effort to satisfy own interpersonal needs, dependency, extreme interpersonal sensitivity, and emotional overreactivity (Bouchard & Sabourin 2009; Lawson & Brossart 2013; Sansone & Sansone 2013; Sansone & Sansone 2015). The relationship either idealizes or demonizes, excessive trust can suddenly change in relativity (Sanislow *et al.* 2000, Stevenson *et al.* 2003 Stevenson *et al.* 2003). Individuals with borderline personality disorder often develop desperate efforts to avoid real or assumed abandonment (APA 2013). Often they will rather leave partner preventively to prevent abandonment (Robinson 2001). Immature defensive mechanisms (projective identification, splitting, denial, projection, displacement) predict marital dissatisfaction and affect pair adaptation (Bouchard & Sabourin 2009). A majority of pairs in which the woman suffered from BPD (68.7%) demonstrated many episodes of breakups and reunions and, over an 18-month period, nearly 30% of these couples dissolved their relationship (Bouchard *et al.* 2009). On the other side, in a longer 15-year follow-up, half of the women and a quarter of men were able to establish stable relationships (Zanarini *et al.* 2003).

Deliberate self-harm

Among the most challenging problems facing the health care professionals working in the clinical practice is the management of the patients with deliberate self-harm (Gunderson 2011; Venta *et al.* 2012; Gratz & Tull 2011). The patients with BPD often exaggerate their response to social stress and engage in cutting to alleviate painful feelings. Self-harm is a robust predictor of suicidal ideation and attempts (Calhoun *et al.* 2017; Terzi *et al.* 2017). Main reasons underlying the self-injuring behavior – feelings of excessive tension, abandonment, self-punishment, and rarely a need for the attention of the others (Gratz & Tull 2011; Hawton *et al.* 2016). Hence, a broader understanding of the reasons for self-injuring is one of needs of the patients with BPD. The patients, who exhibit the self-injuring behavior, need behavioral, pharmacological, and psychotherapeutic strategies to encounter their complex needs (Loughrey *et al.* 1997). Barnicot *et al.* (2016) made a meta-analysis of randomized controlled trials comparing psychotherapeutic interventions and the medication, and no evidence of the efficacy was found for the non-suicidal self-injury, except for the mentalization-based therapy. However, the behavioral and CBT approaches were not included in this meta-analysis. Gratz & Tull (2011) examined the efficacy of a 14-weeks, adjunctive group emotion regulation therapy for the deliberate self-harm among the BPD women.

Although the outcomes of this study were hopeful (indicating positive effects of this treatment on psychiatric symptoms, intentional self-harm, and emotion dysregulation), they should be replicated to confirm its results.

Parasuicides

The term parasuicidality refers to a recurrent suicidal behavior, gestures, threats or self-mutilating behavior (APA 2001; First *et al.* 1994; Giesen-Bloo 2006; Leppänen *et al.* 2016). For the BPD patients with parasuicidality, the early maladaptive schemas of the emotional deprivation, abandonment/instability, mistrust/abuse, and social isolation are the most prevalent (Young 1994; Arntz *et al.* 1999; Farrell & Shaw 2012). For these patients, the schema modes of the vulnerable child, angry child, detached protector, and compliant surrender are prominent (Leppänen *et al.* 2016). Also, Ellenhorn (2005) discusses that parasuicidality frequently arises from the symbiotic link between persons with certain existential needs and the medicalized organizations that serve them.

The BPD patients with tendencies towards the parasuicidal behavior are likely to benefit from working with early maladaptive schemas in the schema domain of disconnection and rejection at an early stage of their treatment (Young 1994).

Suicidality

About 80% of the patients with BPD have a history of suicide attempts, and up to 10% commit suicide (Soloff *et al.* 2005). The suicide mortality rate in the people with BPD is almost 50 times higher than that in the general population (Lieb *et al.* 2004; Chesney *et al.* 2014). BDP patients at increased risk for suicidal behavior include individuals with prior attempts, comorbid with major depressive or a substance use disorder (Black *et al.* 2004). Hopelessness and impulsivity independently increase the risk of suicidal behavior, as does a turbulent early life (Soloff *et al.* 2008). High-lethality suicidal attempters among BPD patients were older, with children, less education, and lower socioeconomic class than low-lethality attempters (Soloff *et al.* 2005). They were more likely to have Major Depressive Disorder, co-morbid Antisocial Personality Disorder, and family histories of substance abuse. Findings from psychotherapy sessions with the BPD patients suggest that the suicidality is usually the most strongly associated with the punitive parent and detached protector modes (Farrell & Shaw 2012; Venta *et al.* 2012). Approaches to expand suicide prevention in the individuals with BPD should be more established. Strategies to diminish suicide require cooperation between the psychiatric care and the social services (Le Gris & van Reekum 2006; Linehan *et al.* 2006).

Comorbidity

BPD is frequently comorbid with other psychiatric disorders (affective disorders, other specific personality disorders, PTSD, eating disorders) (Corruble 1996; Grant *et al.* 2008; APA 2013). The comorbid BPD worsen the treatment of other psychiatric disorder. For example in the case of depression, the presence of BPD can be a predictor of persistence of depression and can prolong the time to remission (Levenson *et al.* 2012; Skodol *et al.* 2011). In the case of comorbidity with depression, anxiety disorder, and bipolar disorder, there is a need for a tailored pharmacotherapy (Corruble *et al.* 1996). The programs for the management of the comorbidity of BPD with other psychiatric disorders are rare and for many comorbidities does not exist. They exist pharmacotherapeutic and psychotherapeutic approaches for the comorbidity with drug and alcohol addiction, eating disorder (Gianoli *et al.* 2012, Gentile 2015, Robinson *et al.* 2016, Martín-Blanco *et al.* 2017). Nevertheless, in many programs for anxiety disorders or depression, the patients with comorbid BPD are treated, and results are encouraging (Prasko *et al.* 2005, Prasko *et al.* 2010, Vyskocilova *et al.* 2011, Prasko *et al.* 2016a, Prasko *et al.* 2016b, Vyskocilova *et al.* 2016)

Mentalization

Mentalization is the process by which humans implicitly and explicitly interpret the actions of themselves and others as meaningful established on intentional mental states (e.g., needs, beliefs, desires, feelings, and reasons)(Bateman & Fonagy 2008). This process is disrupted in the individuals with BPD who frequently misunderstand others' intentions (Bateman & Fonagy 2010). Lack of flexibility puts the individual at risk to unexpected breakdown when the schematic picture is confronted (Bateman & Fonagy 2010). This exposes feelings of the humiliation, which can only be avoided by manipulation, aggression, or the control of the other individual. The shared path to violence is via a temporary inhibition of the capacity for mentalization. Better mentalization could be developed using mentalization-based therapy (Bateman & Fonagy 2010). The emphasis of the treatment is on helping the patients to maintain mentalization about their mental states when their personal integrity is confronted (Bateman & Fonagy 2008).

Identity disturbance and inconsistency in the self-image

Westen and Cohen (1993) described BPD patients with lack of consistently invested goals, values, ideals, and relationships. Identity disturbance is a complex variable that consists of several measurable elements. According to Kernberg (1993), diffusion of identity results from an inability to integrate positive and negative representations of one's self. Four components were evaluated in identity disturbance (Wilkinson-Ryan & Westen 2000; Chabrol *et al.* 2001; Ghaffari Nejad *et al.* 2010): (a) *role absorption* (patients act to over-identify with a particular group and accept their role as the only role in own life); (b) *painful incoherence* (frustration and worry about the sense of self); (c) *inconsistency* (incoherence in thought, feelings, beliefs and behaviours with own

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sense of unpredictability); (d) lack of commitment (to social or work responsibilities aims and values).

Needs connected with the treatment

The BPD treatment can be reasonably effective when specific kind of therapy is applied, like dialectical behavioral therapy (Herschell *et al.* 2009; Quinn & Shera 2009; Bohus & Kröger 2011; Burroughs & Somerville 2013), transference focus therapy (Hawton *et al.* 2016), mentalization therapy (Bateman & Fonagy 2010), or schema therapy (Giesen-Bloo *et al.* 2006; Nadort *et al.* 2009). Nevertheless, several problems still exist: the therapy may not be accessible, and if it is, many patients drop out or do not fully respond to it.

The needs connected with the treatment could be divided into several distinct subcategories, as needs for (a) the early diagnosis; (b) an early intervention; (c) a holding environment; (d) a therapeutic relationship; (e) an assertive community treatment; (f) destigmatization; (g) overcome barriers to help seeking; (h) incarcerated individuals; (i) hospitalizations; (j) a primary care and medical setting.

Needs for the early diagnosis

The diagnosis and treatment of BPD are often postponed (Chanen 2015; Desrosiers *et al.* 2015). The delayed treatment can be associated with unrecognized patients suffering from BPD treated in psychiatric condition because of a comorbid disorder, such as depression, anxiety disorders, substance abuse disorders, eating disorders, bipolar disorder, adjustment disorders, and other mental conditions (Fabrega *et al.* 1993; Deans & Meocevic 2006; Forsyth 2007). Other possibilities of manifestations in the primary care and the general medical settings are pain sensitivity with the unsubstantiated chronic pain and multiple somatic complaints like somatization disorder and somatic preoccupation (Sansone & Sansone 2015). An unrecognized diagnosis of BPD is connected with inadequate treatment (mostly pharmacotherapy), which mostly focuses on the comorbid disorder and lead to treatment resistance and early relapses of the comorbid disorder (Fabrega *et al.* 1993; Zimmerman 2016).

Needs for the early intervention

The knowledge of the possible adolescent diagnosis of BPD has led to the controlled treatment trials, which have established that early intervention through the appropriate BPD diagnosis and treatment leads to clinically meaningful improvements for the adolescent patients (Chabrol *et al.* 2001; Santisteban *et al.* 2015). To progress early intervention for BPD, the access to evidence-based managements needs to develop, the range of available treatments needs to increase, the therapy need to be matched to the individual development and the phase and stage of disorder, and workforce development strategies need to update culture, knowledge, and practice in relation to the people with BPD (Spence *et al.* 2008).

Santisteban *et al.* (2015) examined the efficacy of two CBT approaches focusing on different mechanisms of change in improving a BPD pattern of behaviors and substance use in adolescents (14–17 years). The adolescent fulfilling the criteria for BDP and substance use disorders were randomized to an integrative BPD-oriented adolescent family therapy or an individual drug counseling. Both approaches had a clinically substantial influence on the BPD behaviors twelve months after their start but had no differential treatment effects. The effect on substance use was more complex.

Needs for holding environment

Many studies have found elevated rates of childhood sexual abuse in BPD patients (Soloff *et al.* 2008; Menon *et al.* 2016). The basic childhood needs were no satisfied in most BPD patients, and the patient typically searches for their fulfilling using many ways, like hypercompensation, manipulation, anger, or suffer without fulfilling. The BPD patients need a holding of their ruthlessness and rage, and also of analytic self-blame (Slochower 1991).

Therapeutic relationship

Ruggiero (2012) described several paradoxes that characterize the therapeutic relationship with the BPD patients, who are continuously looking for the interaction with the object which is inevitably traumatic for them. Countertransferential problems are unavoidably principal because of the impending threat of the destruction of the therapeutical relations. Continuing a balance between the recognition-legitimization of primary narcissistic mirroring needs and the recognition control of narcissistic demands and attacks on the logical link is as crucial as it is complex. Ruggiero (2012) looks at the most significant therapeutic and anti-therapeutic aspects, stress the prominence of countertransference analysis and self-reflection as ways of accessing as yet unrepresented elements of the patient and therapist respectively.

Assertive community treatment

Assertive Community Treatment (ACT) programs were established to address the treatment needs of severely mentally ill individuals usually suffering from chronic mental illnesses. Still, the ACT programs are seeing an increasing number of people with co-morbid BPD (Burroughs & Somerville 2013). The efficiency of the traditional ACT programs in treating BPD is unclear, but the dialectical behavior therapy has been suggested as an efficient method of treating the patients with BPD in this setting (Burroughs & Somerville 2013).

Destigmatization

The study of Knaak *et al.* (2015) presented that stigma towards persons with BPD was significantly higher than the stigma of individuals with other mental illnesses. These findings also add further support to literature

showing that stigma varies by diagnostic group (Pescosolido *et al.* 1999; Pescosolido *et al.* 2010). When matching BPD to other highly stigmatized disorders such as psychoses or bipolar affective disorder, attitudes and behaviors towards patients with BPD have a tendency to be more negative (Fraser & Gallop 1993; Markham & Trower 2003; Forsyth 2007).

There are investigations on psychoeducation as an effective strategy for BPD with the patients and family members (Banerjee *et al.* 2006; Murray-Swank & Dixon 2006; Zanarini & Frankenburg 2008; Long *et al.* 2015; Gunderson *et al.* 1997). There is also some research suggesting psychoeducation can improve clinician's attitudes (Krawitz 2004; Commons Treloar 2009; Shanks *et al.* 2011). Results of the study of Knaak *et al.* (2015) suggest that the targeted intervention was effective at improving the healthcare provider attitudes towards the individuals with BPD and psychiatric and other disorders more generally, although the shift in the attitudes towards the people with specific disorders was substantially less significant than that towards the individuals with BPD. The attitudes towards a highly stigmatized disorder like BPD can improve through quite small interventions if those interventions are designed and delivered properly (Knaak *et al.* 2014). Significant decreases in stigma were achieved with only a three-hour program, even when the target audience was a group of practicing providers with substantial experience with psychiatric patients outside of this workshop.

Stigmatization among healthcare staffs towards persons with a mental disorder is supposed to present complications to effective caregiving (Aviram *et al.* 2006; Lauber *et al.* 2006; Schulze 2007; Thornicroft *et al.* 2007). This may be predominantly the position for the individuals with BPD, where it has been suggested that adverse reactions can lead to counter-therapeutic conditions as well as premature end of treatment, rationalization of the treatment failures, a lower probability of creating an effective therapy alliance with the patient, social and emotional distancing, troubles with empathizing, an absence of a belief in recovery, and views of the patients as manipulative, unrelenting, powerful, dangerous, and more in control of their behaviors than other patients (Frazer & Gallop 1993; Markham & Trower 2003; Markham 2003; Aviram *et al.* 2006; Forsyth 2007; Sansone & Sansone 2013). There is a considerable need for education and training aimed at improving the healthcare providers' attitudes, as well as their capability to interact effectively with the individuals with BPD (Krawitz 2004; Commons Treloar 2009; Shanks *et al.* 2011).

Barriers to help-seeking

Outcomes for probands with BPD across sexes were prominent for comparable high lifetime ranks of use of care, including day programs, hospitalization, and halfway houses, but not comparable levels of use services of drug/alcohol rehabilitation, which was greater among the male subjects with BPD (Goodman *et al.* 2010). The men with BPD receive considerably less lifetime pharmacotherapy and psychotherapy than the women with BPD, although the duration of pharmacotherapy and psychotherapy does not differ by sexes.

Kealy & Ogrodniczuk (2010) examined the exclusion from the appropriate mental health care and the opportunities for recovery in BPD using the social construct of marginalization. Persistent attitudes among the mental health professionals, care administrators, and policy-makers maintain the marginalization of the patients with BPD in the systems of the health care. The BPD patients may be viewed as not suffering from a real disorder, containing a minority of the clinical population, and being a prolonged drain on health care resources. The absence of appropriate services may be based on such labeling attitudes. Substantial growth in the realistic understanding of the patients with BPD challenges these stigmatizing beliefs and requests for serious searching of the marginalized position of the BPD patients is needed (Kealy & Ogrodniczuk 2010). Because the men with BPD receive considerable less lifetime treatment than the women, there is the need for more studies to a better understanding of what might account for these sex differences in the treatment and expand strategies to deliver proper care for the male BPD patients.

Hospitalization

The countertransference prompted in the staff may provide a crucial signal function reflecting the patient ward system (Rosenbluth 1991). Understanding this state of mind offers the material not only about the patient's inner world but also about overall system features such as the staff's needs, therapeutic capacity and unanswered feelings from the earlier BPD patients. This indicator meaning may also have diagnostic and treatment consequences. A conceptualization of countertransference that includes the special system features of inpatient psychiatry is useful in the care of the BPD patients. In a focus group of the hospitalization in patients with personality disorders, five overarching themes were recognized: feasibilities of ward life; having an ability to speak; revolving door patients; the power of sectioning and the 'personality disorder' label (Rogers & Dunne 2011; Rogers & Acton 2012). Some nurses describe individuals diagnosed with BPD as among the most difficult and challenging patients met in their practice. As a consequence, the argument has been made for the nursing staff to accept a clinical supervision to improve the therapeutic efficiency and treatment results for the persons with BPD (Bland & Rossen 2005). Clients, who have BPD, have unique needs for a family connection in their treatment, and inpatient staff professionals need to be conscious of such needs (Hartman & Boerger 1990). Founding and continuing therapeutic relationships with family members are essential.

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Needs connected with primary care and general medical settings

Excessive utilization of healthcare and high healthcare costs are ardent issues in today ‘s economic climate. BPD seems to be one of the contributing variables (Sansone *et al.* 2012). The patients with BPD features consistently evidenced a greater number of office visits and documented prescriptions (Sansone *et al.* 1998; Sansone *et al.* 1996), more contacts with the treatment facility (e.g., telephone calls) (Sansone *et al.* 1996), and more frequent referrals to specialists (Sansone *et al.* 1996a), i.e. an overall greater utilization of health care resources. The individuals with BPD in medical settings manifest physical symptoms that are medically difficult to substantiate. Diagnosis of this disorder and its possible manifestations in the medical setting is continuing to unfold (Sansone & Sansone 2015). Some aggressive or disruptive behaviors are clinically associated with BPD (i.e., demandingness, or intimidation, refusing the treatment, angry outbursts that are grossly out-of-proportion to the situation). The number of different disruptive office behaviors can be correlated with BPD as well as the following specific office behaviors-refusing to talk to the medical personnel, making verbal threats, screaming, yelling, and talking disrespectfully about the medical staff to both family and friends (Sansone *et al.* 2010). The intentional sabotage of the healthcare melds well with BPD as such behaviors may function as the self-injury equivalents (i.e., less recognizable variants of self-harm behavior) (Sansone *et al.* 2012). Additional possible behavioral variation of making medical situations worse is the phenomenon of preventing wounds from healing.Such behaviors are frequently linked to the feeling of abandonment, stigmatized or fear of the disorder and its consequence. BPD patients need professional help for understanding and sharing painful feeling connected with the physical disorder and treatment.

Needs connected with the quality of life

Economic situation (financial) problems and challenges with keeping the occupation are typical distresses articulated by the BPD patients (van Asselt *et al.* 2008; Gerson & Rose 2012; Paris 2012; Pompili *et al.* 2014; Crawford *et al.* 2015; Ten Have *et al.* 2016). Many persons with BPD deal with with the problems of separation from the family, family violence, divorce, rape, abuse (sexual, physical, and emotional), loss of children, and homelessness (Arntz *et al.* 1999, Holm & Severinsson 2008; Lobbestael & Arntz 2010; Lawson & Brossart 2013; Sauer *et al.* 2014; Schoenleber *et al.* 2014; North 2015; Whitbeck *et al.* 2015; Bovin *et al.* 2017). The disorder interferes with life experiences of many patients, who reported interference with study plans, interpersonal relationships, career, and the establishment of their family (van Asselt *et al.* 2008; Bouchard *et al.* 2009; Spindler 2009; van Asselt *et al.* 2009). BPD is accompanying with elevated levels of health resource usage (Horz *et al.* 2010) and with adversarial long-term consequences that include severe and persistent functional disability (Gunderson *et al.* 2011), high family and career burden (Hoffman *et al.* 2003), physical ill health (El-Gabalawy *et al.* 2010; Frankenburg & Zanarini 2004) and premature mortality (Fok *et al.* 2012; Chesney *et al.* 2014; Cailhol *et al.* 2017).

Family needs

It is principally essential to include the patient’s significant others in the treatment of the patient’s disorder and challenges, and thereby learn how to be able to cope with the disorder more effectively (Miller 1995). Family members can be vital in providing support for dealing with the challenging process of obtaining a new skill set. They are more likely to provide this kind of support if they have been part of the assessment and treatment process. Parents diagnosed with BPD often to discover the emotional facets of parenting challenging (Newman *et al.* 2007). Mothers suffering from BPD were found to be less sensitive and showed less organization in their communication with their infants, and their infants were found to be less attending, less interested, and less enthusiastic in interacting with their mothers in comparison with the community mothers and their babies (Newman *et al.* 2007). Additionally, the mothers with BPD described themselves being less satisfied, less competent and more distressed.

Need for the physical health

Patients with BPD are known to be heavier users of both mental and medical health care systems, especially in emergency settings, than patients with other clinical conditions such as depression (Chesney *et al.* 2014; Cailhol *et al.* 2017). In the study of Chesney *et al.* (2016) BPD patients had a higher mean number of medication prescriptions, general medical consultations and days of medical or surgical hospitalizations in comparison with two control groups: one with other personality disorders and one with matched subjects randomly selected from the general population. There is also the increasing evidence that people with personality disorder have similar patterns of early mortality and physical comorbidity as those with other severe mental illness (Fok *et al.* 2012; Cailhol *et al.* 2017).

Spiritual needs

The persons with BPD often question the purpose and value of their life (Ellenhorn 2005; Liu *et al.* 2011; Weibel *et al.* 2017). Small feelings of meaning in life are connected with depression, hopelessness and suicide, substance abuse and emotional dysregulation. Patients with BPD had a lower feeling of meaning in life than the patients with mental disorders but without a BPD (Marco *et al.* 2017). Understanding the spiritual needs of the BPD patients is essential to provide more appropriate care and achieve a greater care efficacy (Marco *et al.* 2017; Weibel *et al.* 2017).

Advocacy needs

The disorder is associated with elevated risk for a variety of dangerous behaviors (Scott *et al.* 2014; Moore *et al.* 2017). Impulsive behavior such as substance or alcohol abuse, promiscuity, anger outbursts, including criminal behaviors, stalking behavior, and self-injuring or suicidal behavior are the most dangerous features (Lewis *et al.* 2001; Sansone & Sansone 2010; Moore *et al.* 2017). Pandya (2014) described the development of advocating for consumers and families affected by BPD. The role of emotion-driven difficulties controlling impulsive behaviors in criminal behaviors is important among persons with BPD. The targeting this mechanism has potential clinical utility to prevent to criminal justice involvement and recidivism (Quinn & Shera 2009; Black *et al.* 2008; Black *et al.* 2013). The trends are closer the ties between advocacy and professional groups and specialization to better address the different needs created by diagnosis (Wanniarachige 2015).

IMPLICATIONS FOR THE TREATMENT

Case management

Before taking the patient with BPD into care, it is appropriate to consider that it will be a long and intensive therapy. The next step should be an installing of balance in what kind of treatment to provide the patient at that time (whether individual, group, pharmacological, psychotherapeutic, outpatient, inpatient, or combined). Working with a borderline patient brings an intense therapeutic relationship, a strong transference and countertransference reactions, which can mean personal maturation of both the patient and the therapist. It is necessary to consider whether we are willing and able to engage in an emotionally significant relationship with the patient and if we are in supervision. It can be expected that there will be many unexpected slumps and setbacks during the therapy.

The management of a patient with BPD assumes understanding her or his fears of abandonment on the one hand, on the other side fear of absorbing by the proximity (Clarkin *et al.* 2004; Young 1994; Verheul *et al.* 2003). In addition to understanding and support, a patient needs clear boundaries of what the therapist and he or she can do and what not during the therapy. The patients with the BPD tend to build relationships with the therapists that are similar to their previous significant relationships. This means that the therapeutic relationship can often be highly volatile, and intensive (APA 2001). Ongoing consultations with colleagues are recommended to address adverse reactions of the therapist to the client (such as distancing, rejection, or abandonment of a patient) which are the countertransference reactions with an experience of anger or frustration at the failures during the therapy. Opposite problem may be not reflected romantic and sexual feelings in response to the patient's seduction, or excessive tying compassion and support in response to the reported patient suffering. In the sessions, there should be an emphasis to build a solid therapeutic alliance, monitoring of the self-injurious and suicidal behavior, validation of the suffering and experiences of abuse (as well as helping the patient to take responsibility for the actions), a support of the reflection instead of the impulsive behavior, and setting limits for the self-destructive behavior (Gunderson 2001). The borderline patient's tendency to split (a polarized emotional response) should also be carefully monitored and addressed (e.g. the earlier devaluation therapists associated with the idealization of the current therapist).

Psychotherapy

Psychotherapy is viewed as the first-line treatment for the people with borderline personality disorder, while pharmacotherapy has a limited efficacy (APA 2001). In past 20 years, several disorder-specific interventions have been tailored to the specific needs of patients with BPD (Stoffers *et al.* 2012). They are *Dialectical behaviour therapy* (DBT; Davenport *et al.* 2010; Linehan *et al.* 2006; Bohus & Kröger 2011; O'Connell & Dowling 2014; van den Bosch *et al.* 2005), *Transference focus therapy* (TFT; Clarkin *et al.* 2004; Hawton *et al.* 2016), *Schema Therapy* (ST; Giesen-Bloo *et al.* 2006; Nadort *et al.* 2009), *Mentalization-based therapy* (MBT; Herschell *et al.* 2009; Nadort *et al.* 2009; Quinn & Shera 2009; Bateman & Fonagy 2010; Bohus & Kröger 2011; Burroughs & Somerville 2013), and *STEPPS* (van Wel *et al.* 2006; Black *et al.* 2008; Blum *et al.* 2008; Davidson 2008; Black *et al.* 2013; Black *et al.* 2016). Each treatment has been demonstrated to reduce the severity of the BPD symptoms, particularly the physical self-destructive behaviors (Zanarini 2009). The efficacy has also been demonstrated in neuropsychological remediation (cognitive rehabilitation) (Pascual *et al.* 2015; Vita *et al.* 2016).

Therapists need to retain their capability to mentalize, continue mental closeness, concentrate on present mental states, and avoid excessive use of conflict interpretation and metaphor while paying careful attention to the use of transference and countertransference (Bateman & Fonagy 2003). Targeting of the current symptomatology and behavior is insufficient. Livesley (2012) claimed that the existing psychotherapies are inadequate because they are not familiar with or accommodate to the extensive heterogeneity of BPD and its multifaceted etiopathogenesis. Based on these factors, it is not possible to apply just one approach in the treatment of the BPD patients. An integrated approach is suggested as an alternative to the specific therapies that use all effective interventions irrespective of their theoretical origins and delivers them in a coordinated way. Livesley (2012) recommended a two-component background for establishing an integrated treatment for BPD patients: (a) the BPD conceptualization based on the existing empirical knowledge about the structure, etiology, and stability of the BPD pathology used as a

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guide for the selection and delivered therapeutic strategies; and (b) a model of therapeutic change founded on the general literature on psychotherapy outcome and specific studies of the personality disorder treatments.

Data about specific group interventions and their relationship to the results for subgroups of the people with BPD are not present in the psychodynamic group psychotherapy (Nehls 1992). However, BPD has been treated in the psychotherapy groups for over 40 years (Roller and Nelson 1999). The combined management of the group and individual therapy addresses the needs for object constancy, the integration of object and self-representations, and the possibility of attachment to others. Collaboration with the individual therapists in this procedure is necessary, and there are strict conditions that let this to occur as well as rules to help them make referrals. Co-therapy can be particularly beneficial if the therapy team is experienced and skilled. The group therapist must have specific training and supervision to lead groups of such intensity and affectively full content (Roller & Nelson 1999).

Pharmacotherapy

The National Institute for Clinical Excellence (NICE) claimed the use of psychopharmacs only in periods of crisis for the persons with BPD (NICE 2009). Regardless of this recommendation, most service users are referred to a specialist, and a personality disorder service was found to be on numerous medications (Rogers & Acton 2012). In the last decade, there has been a progress in the number and quality of the studies of the pharmacotherapy of BPD, with the increase in the number of randomized, placebo-controlled, double-blind studies (Grootens & Verkes 2005; Binks *et al.* 2006; Herpertz *et al.* 2007; Kapoor 2009; Lieb *et al.* 2010; Mercer *et al.* 2009, Paris 2009; Saunders & Silk 2009; Stoffers *et al.* 2010; Bellino *et al.* 2011; Feurino & Silk 2011; Ingenhoven & Duivenvoorden 2011; Paris 2011; Ripoll *et al.* 2011; Vita *et al.* 2011; Ripoll 2012). The placebo-controlled studies in this area are of particular importance due to the high level of response in the patients with BPD on placebo. However, the latest Cochran's meta-analysis concluded that the pharmacotherapy for BPDis not based on a robust evidence from studies, but is supported by only a "very sparse" evidence from randomized controlled trials (RCTs) and "only a few study results, compared with the small number of included participants." The authors concluded that there is some support in the research for the administration of the second generation of antipsychotics, mood stabilizers, and omega-3 fatty acids, but these studies require replication because most estimates of the effect are based on the effectiveness in one study (Lieb *et al.* 2010). They also pointed out that there is no conclusive evidence that any drug reduces the severity of BPD.

Drugs rather work for specific dimensions symptoms (Stoffers *et al.* 2010). Specifically, it appears that for example, the effectiveness of the second generation antipsychotics aripiprazole leads to reduced interpersonal problems, impulsivity, anger, psychotic symptoms, touchiness oversensitivity, depression, anxiety, and general psychiatric pathology (Stoffers *et al.* 2010). For olanzapine, there was no significant effect on the primary criteria relevant for the diagnosis of BPD. A secondary analysis, however, showed a significant reduction of affective instability, anger, psychotic, paranoid symptoms, and anxiety. Weight gain in some patients with this drug can be problematic and can affect the acceptance of its use. Interestingly, the tolerability of the treatment arms did not differ between a drug and a placebo (Stoffers *et al.* 2010).

Anticonvulsant mood stabilizers also appear promising. Valproate has a significant effect on improving interpersonal problems, depression, and anger, but because of the proven teratogenicity to the fetus and a higher incidence of the polycystic ovary is better to avoid in the treatment of young women (Verrotti *et al.* 2016). Lamotrigine reduces impulsivity, anger (Reich *et al.* 2009; Crawford *et al.* 2015). Topiramate can be particularly acceptable to the patients because it is not associated with weight gain, but rather with a slight weight loss (Loew *et al.* 2006; Kazerooni & Lim 2016). As far the antidepressants, the only significant effect is observed with amitriptyline in depressive symptoms, although SSRI, mianserin, and MAOIs show a pronounced effect when the patient suffers from a co-morbid depressive or anxiety disorder (Soloff *et al.* 1989; Stoffers *et al.* 2010). The omega-3 fatty acids have been found to have a significant effect on suicidality and depressive symptoms (Stoffers *et al.* 2010). In contrast, the British National Institute for Health and Clinical Excellence (NICE 2010) compared the previous recommendation does not consider any medication for the demonstrably beneficial either for signs of BPD and also criticizes the interpretations and guidelines of APA for the treatment of BPD. All in all, it can be stated that:

a. The pharmacological treatment of the patients with BPD should be focused on defined symptoms.
b. Treatment of a given drug should be of a sufficient duration (depending on the pharmacokinetic and dynamic properties of the drug) to assess that brings some advantages, but it should be stopped or changed if no benefits are apparent.
c. Any evidence does not support polypharmacy, and it should be avoided whenever possible.
d. Particular attention should be paid to the toxic effects in cases of an overdose (e.g. by tricyclic antidepressants) and to the potential for abuse or dependence (e.g. on hypnotics and sedatives).
e. In the presence of comorbid disorders, it is appropriate to treat the comorbid disorder by standard procedures.

The research in the psychopharmacology and neurobiology of the personality disorders is still in its infancy compared with other psychiatric disorders. Some clini-

cal trials have various limitations, and many have only a small sample size. Moreover, the evidence indicating the improvement of the symptoms using pharmacotherapy in the BPD patients is rather weak. A certain caution in the indication of psychotropic drugs can be recommended. Psychotherapy is considered to be the primary treatment for BPD, while pharmacotherapy has limited efficacy. The most critical need of the patients is to find an experienced therapist and receive a long-term systematic psychotherapy.

CONCLUSION

Monitoring the patients' needs is relevant for the treatment of the individuals suffering from BPD. However, many needs remain unmet in the areas linked to medical, personal, and social factors. A greater focus on the patients' needs could be valuable and should be directed to the treatment.

Conflict of Interest Statement. *None to declare.*

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