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ORIGINAL ARTICLE

Borderline personality disorder and recovery

Vlastimil Nesnídal[1], Jan Prasko[1,2,3], Jakub Vanek[1], Marie Ociskova[1], Michaela Holubova[4], Krystof Kantor[1], Klara Latalova[1], Kamila Minarikova[1], Frantisek Hodny[1]

1 Department of Psychiatry, Faculty of Medicine and Dentistry, University Palacky Olomouc, University Hospital, 77520 Olomouc, Czech Republic
2 Institute for Postgraduate Education in Health Care, Prague, Czech Republic
3 Department of Psychology Sciences, Faculty of Social Science and Health Care, Constantine the Philosopher University in Nitra, Slovak Republic
4 Department of Psychiatry, Regional Hospital in Liberec

Correspondence to: Prof. Jan Prasko, MD, PhD
Department of Psychiatry, University Hospital Olomouc, I. P. Pavlova 6,
775 20 Olomouc, Czech Republic
e-mail: praskojan@seznam.cz

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Abstract

Recovery focuses on the broader concept of having a good life with mental health problems than remission. This review aims to deliver up-to-date information on the concept of recovery in borderline personality disorder. A computerized database search was conducted in PubMed and Web of Science sites, using various combinations of keywords for the period between January 1990 and April 2020. According to current findings, a full remission or complete disappearance of symptoms of a borderline personality disorder usually does not occur soon after the initiation of treatment, but recovery is an achievable goal. A precondition for recovery is the patient's responsibility for their health. Apart from psychotherapy and psychosocial rehabilitation, pharmacotherapy can help individuals with BPD improve their quality of life and can provide significant aid on their path to recovery.

INTRODUCTION

Patients with a borderline personality disorder (BPD) face problems with emotional regulation, impulsiveness, instability of mood, feelings of emptiness, behavioural dysregulation, and unbalanced patterns and shifts in their relationships (APA, 2013). BPD disturbs every part of a patients' life (e.g., education, work, relationships with others, or self-care) (Murphy *et al.* 2019).

The diagnosis of BPD is often controversial or inadequate. However, the prevalence of BPD is estimated to be 1.1% of the general population (Ten *et al.* 2016). BPD belongs among the most common personality disorders in clinical populations. As such, it is identified in up to 10 % of outpatients and 25 % of inpatients (Widiger & Weissman, 1991; Zimmerman *et al.* 2005; Gunderson, 2009). BPD is frequently accompanied by suicidal behaviour and self-harm. Self-harm, such as body cutting, burning, etc., is one of the main reasons for their psychiatric hospitalization (Markham & Trower, 2003; Goodman *et al.* 2017; Sansone et al. 2018). BPD leads to low quality of life, low psychosocial functioning, and high societal costs (Higgitt & Fonagy, 1992; Comtois & Carmel, 2016; Fassbinder *et al.* 2018; Murphy

et al. 2019). Experts, who treat these patients, can often feel exhausted and desperate due to the small or seemingly no effect of the treatment (Markham & Trower, 2003; NIMHE, 2003; Skegg, 2005). From all psychiatric hospitalizations, 20 % are BPD patients (Comtois & Carmel, 2016; Slotema *et al.* 2017; Lewis *et al.* 2019), 78 % of BPD patients have substance use issues (Kienast *et al.* 2014; Heath *et al.* 2018; Parmar & Kaloiya, 2018), and about 79 % of BPD patients attempt suicide at least once in their lives (Gunderson, 1984; Frances *et al.* 1986; Zanarini *et al.* 2008; Joyce *et al.* 2010; Goodman *et al.* 2017; DeShong & Tucker, 2019; Paris 2019), and 10% eventually take their lives (Cailhol *et al.* 2017; Kjær *et al.* 2018; Kuo *et al.* 2019). Statistics such as these illustrate the severe effects that the presence of BPD can have on an individual, when not treated timely, adequately, or not treated at all.

Concept of recovery in psychiatry

Recovery consists of a sense of self-control, social support, empowerment, support for adaptive coping skills, and a sense of meaningfulness (Jacob, 2015; Lahera *et al.* 2018). Unlike clinical remission, which is well-defined and can be measured, the concept of recovery encompasses multiple aspects of the patient's life, making it challenging to settle on a definition and to develop reliable assessment criteria. Liberman *et al.* (2012) described operational criteria for recovery from psychosis that involved remission of symptoms, improved occupational functioning, independent living, and better peer relations. In contrast, Anthony (1993) defined functional recovery as a profoundly individual, exceptional process of changing personal feelings, aims, values, attitudes, skills, and/or roles, within limits given by the disorder. Some clinicians have recommended that functional recovery should only be recognized when symptoms are mild and stable enough so that they do not interfere with social functioning and relationships (Liberman *et al.* 2002; Liberman, 2008). The essence of recovery is not a specific change of symptoms, but an emphasis on the human functioning, quality of life, and human potential (Roberts & Wolfson, 2004; Corrigan *et al.* 2014; Jacob, 2015; Bejerholm & Roe, 2018). Generally, the recovery model is a patient's subjective assessment in following areas (Ralph *et al.* 2002; Corrigan *et al.* 2012): (a) meaningful and satisfying personal life; (b) freedom to make decisions about one's life goals and treatment; (c) hope for the future; (d) being at peace with yourself; (e) having a valuable sense of integrity, well-being, and self-esteem.

Recovery is not remission

A patient can be viewed as recovered and still meet the diagnostic criteria for the disorder. Approaches to the mental health recovery, such as Wellness Recovery Action Planning (Copeland, 1997), are taken as an alternative to clinical remission models that are commonly focused on the treatment of disease (Deegan, 1996; Lahera *et al.* 2018). Five processes can characterize recovery (Tew *et al.* 2012): (a) Strengthening and regaining control of one´s life; (b) Rebuilding positive personal and social identities; (c) Coherence (personal and more general aspects of social inclusion); (d) Hopefulness and optimistic notion about the future; (e) Finding the meaning of one´s life.

Because the recovery assessment is subjective, there may be situations where both individuals with quality social life and stable work and those in need of constant care and objectively dependent on others feel recovered. (Slade *et al.* 2008). For this reason, more objective criteria describing the recovery in psychiatric disorders have been developed (Liberman *et al.* 2002; Lahera *et al.* 2018):

(a) Mild or infrequent symptoms that do not interfere with daily functioning;
(b) The ability to have a job and work in a competitive work environment at least part-time, or attend school regularly;
(c) Have adequate family relationships in which occasional family disputes are a normal part of life;
(d) Building social relationships with at least one friend with whom the patient engages in some form of communication or social recreation at least every two weeks;
(e) Lead an independent life defined by independence in the area of managing personal finances, self-care, and adequate personal hygiene.

OBJECTIVES OF THE STUDY

This review aimed to map the existing literature on BPD manifestations over time and to explore whether the concept of recovery, which is more and more commonly used in psychotic disorders (schizophrenia, delusional disorder), can be used in patients with a borderline personality disorder as well. Research questions of interest were the following:

(1) Are features of borderline personality disorder permanent, or are they subjected to significant changes in time?
(2) Does the concept of recovery make sense in patients with a borderline personality disorder?
(3) How does the recovery in borderline personality disorder look like?
(4) Does the recovery occur during and/or after the treatment of borderline personality disorder?
(5) Which therapeutic strategies help to achieve recovery in patients with a borderline personality disorder?
(6) What is the patient's responsibility for recovery?

METHOD

The search of narrative review focused on scientific articles published between January 1990 and April 2020 in the PubMed and Web of Science databases.

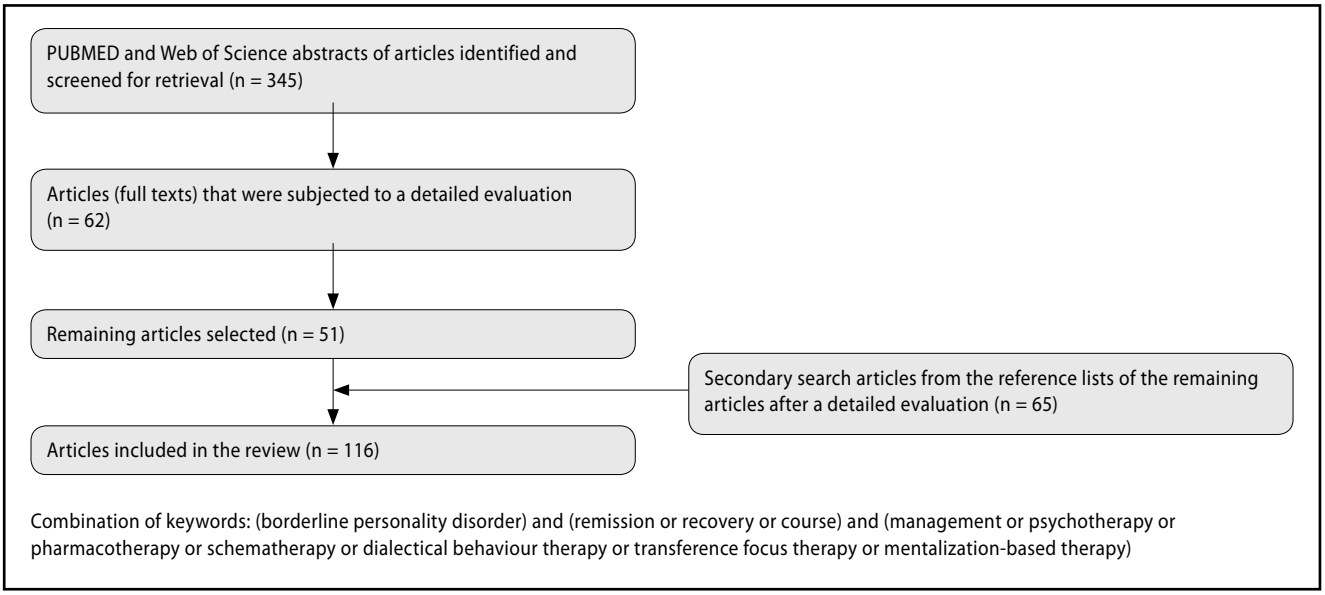

Fig. 1 . Summary of the selection process

The documents were extracted using the keywords "borderline personality disorder", "recovery", "management", "pharmacotherapy", "psychotherapy", "therapy" and "treatment" in various combinations. The filters used were: people; published in peer-reviewed journals; the articles could be prospective, retrospective original studies; or review; contributions were published in English. The exclusion criteria were abstracts from conferences, commentaries and dissertations. Three hundred forty-five articles were identified eligible for examination; 62 articles were included according to the selection criteria. After a detailed evaluation of identified articles, 51 were chosen. Based on the selection criteria, we also selected secondary articles from the reference lists of the primary identified documents. There were 65 significant articles, and these were added to the first list to a total of 116 articles. The flowchart summarizes the total number of documents reviewed and the number of those involved in the review process according to PRISMA guidelines (Moher *et al.* 2009) (Figure 1).

RESULTS

The results are organized according to the six main categories: (1) Stability of borderline traits during the time; (2) The concept of recovery in patients with BPD; (3) Clarification of the recovery concept in borderline personality disorder; (4) Recovery and treatment of borderline personality disorder; (5) Therapeutic approaches useful for achieving recovery in BPD; (6) Patient's responsibility for their recovery.

(1) Stability of borderline traits during the time

Some experts and the general public tend to perceive personality disorders as incurable and permanent (Adshead, 2001; de Barros & de Pádua Serafim, 2008). However, there has been recent evidence contradicting this outdated reasoning and showing that the symptoms of BPD diminish over time (Zanarini *et al.* 2010). The symptoms of BPD develop most frequently during adolescence, and the disorder is usually diagnosed in early adulthood (Westen *et al.* 1990; Ryan 2005; APA 2013). However, symptoms of BPD diminish earlier than was previously thought. According to Vriend-Bosm & van Megen (2011), up to 88 % of patients diagnosed with BPD by DSM-IV do not meet diagnostic criteria within ten years of diagnosis. All symptoms showed a significant improvement in the follow-up. Recent evidence suggests that the severity of BPD symptoms in treated individuals decreases significantly over time. Investigations from the United Kingdom and the United States showed that less than half of the patients, who initially met the BPD criteria, still meet them six years later (Davidson *et al.* 2010) and the number fell to 26 % after ten years (Zanarini *et al.* 2003).

The problems associated with BPD are most pronounced in early adulthood and gradually disappear until they vanish entirely from everyday life (Zanarini *et al.* 2015). The intensity of these problems is also eased due to early treatment. In a study of hospitalized and subsequently discharged BPD patients, up to 70 % of them did not meet the BPD criteria after six years (Zanarini *et al.* 2003). In this group, up to 94 % of patients had no relapse and lived without symptoms. These results are consistent with the results of two other studies on the same subject (Davidson *et al.* 2010; Skodol *et al.* 2005).

In summary, BPD is a treatable disease and occur most frequently during adolescence and gradually disappear in adulthood. Symptoms of BPD may change over time, fortunately mostly in the direction

of recovery. The intensity of symptoms or some of the functional problems are losing original gravitas.

(2) The concept of recovery in patients with BPD

Many patients with a borderline personality disorder do not profit from evidence-based treatments since they frequently do not seek them or do not adhere appropriately to them (Paris, 2012). The National Institute for Health and Care Excellence (NICE 2003) has developed a guideline for the treatment of patients with BPD that refers to the possibility of recovery. This concept has also been used in other mental health care services and has been translated into approaches to the services to patients with personality disorders (NCSMH, 2009). The term 'capabilities framework' has been developed, which is defined as the set of capabilities needed to treat personality disorders (NICE, 2003). It also stresses the importance of developing the skills of the care providers to support clients with personality disorders in the recovery process. However, this procedure does not specify how to understand recovery in the context of personality disorder. At the same time, there is a lack of qualitative research to describe clients' experiences with personality disorders (Castillo, 2003).

According to Zanarini *et al.* (2012), BPD remission has been defined as a state in which a person no longer meets the criteria for a Revised Diagnostic Interview for Borderlines and DSM-III-R or another personality disorder for two years or longer. It is a question whether the condition corresponding to the above definition can be referred to as remission or recovery. Therefore, a global functional score rating of 61 or higher was chosen as a measure of recovery. This score provides a sufficiently good description of the overall outcome of the treatment (i.e. with mild symptoms or difficulties in social, professional or school activity, where the individual generally functions and has at least one meaningful interpersonal relationship). The authors further operationalized this score. In order to increase its reliability and significance, and to reach to this score or higher, the subject usually had to remit from their primary axis II diagnosis, had at least one emotionally maintained relationship with a close friend or life partner, and was able to attend full-time work or school consistently and competently.

The framework of recovery can help to find treatment goals that patients subjectively perceive as meaningful, primarily since full remission or disappearance of symptoms of borderline personality disorder may not occur within an acceptable time.

In summary, the recovery process needs to consider the patient's subjective view of their difficulties and to function in the individual areas of life in which recovery is closely monitored. However, patients may differ in their perception of what problem is for them and what their goals are, both among themselves and in comparison, to the care provider.

(3) Recovery and treatment of borderline personality disorder

Two extensive studies have been published. In the first, several hundred BPD patients, who participated in an outpatient program aimed at stabilizing the condition, were followed for ten years (Skodol *et al.* 2005). About 85 % of BPD patients had a symptom-free period of twelve months or longer. Only 11 % of patients in this group experienced any recurrence of problems. This means that approximately 77 % of BPD patients, who received treatment, became asymptomatic over time. The rate of improvement was highest compared to other types of personality disorders. The second study conducted an open-label follow-up in nearly 300 BPD patients, who were discharged after hospitalization (Zanarini *et al.* 2015). During 16 years, 99 % of participants treated with BPD reached a symptom-free period of 2 years or more. For 78 % this period lasted at least eight years. However, the improvements described by the studies above cannot be viewed as a sign of a complete cure. Results point out that despite many prejudices, the group of patients with BPD is open to treatment and can be treated well. Time and treatment are important factors that can significantly help an individual suffering from this severe disorder.

Two other smaller studies (Katsakou *et al.* 2012; Gillard *et al.* 2015) reported that recovery means alleviation of symptoms such as self-harm, suicidality, depression and anxiety, further self-understanding, self-acceptance, better emotional control, improved relationships, and work performance. They felt that psychotherapy was often overly focused on specific areas, such as self-harm or relationships, and ignored other goals, like the quality of life or well-being. Full remission was considered as a distant goal, but patients felt they could learn how to deal with their difficulties more effectively and make significant progress in their lives through smaller steps. Little relief from the symptoms is not enough and adaptation in life is crucial. The authors concluded that positive personal and broader social relationships are critical factors in facilitating recovery (Gillard *et al.* 2015).

In summary, patients with BPD can profit from treatment. Symptoms-free periods and recovery are, given time and appropriate treatment, achievable and realistic therapeutic goals for many patients with a borderline personality disorder.

(4) Therapeutic approaches useful for achieving recovery in BPD

Treatment should be provided as soon as possible after diagnosis, since individuals suffering from BPD may be severely affected by their problems and symptoms. In the first weeks of treatment, it may be useful to initiate care in an inpatient facility, that has experience and erudition to provide care to patients suffering from BPD and offers a safe environment. The therapy initially focuses on improving the understanding of the

disorder, self-acceptance and reducing symptoms in a supportive environment (Bateman A & Fonagy, 1999; Bartak, 2001).

There is no treatment for BPD that would surely help all patients. As with many other mental disorders, the aim is to reach and prevent the relapse of the disorder and to improve adaptation and quality of life (Katsakou *et al.* 2012). However, it is possible to stabilize the patient for a long time and to teach them to master coping strategies that allow living in a compensated state (Paris 2011). As many studies show, the long-term treatment is beneficial when adequately selected (Doering *et al.* 2010; Bartak *et al.* 2011; Bateman & Fonagy, 2008; Brazier *et al.* 2006; Davidson *et al.* 2006; Giesen-Bloo *et al.* 2006; Clarkin *et al.* 2007; Lynch *et al.* 2007; Dickey & Ware 2008; Farrell *et al.* 2009; Kliem *et al.* 2010).

Psychotherapy

Several types of psychotherapy have shown efficacy in the treatment of BPD. These therapies include Transference focused therapy (TFP), Dialectical behavioural therapy (DBT), Mentalization-based therapy (MBT), and Schematherapy (ST) (Cristea *et al.* 2017; Oud *et al.* 2018). TFP focuses on the treatment of personality disorders, especially BPD and narcissistic, to reduce suicidal behaviour and improve self-control (Clarkin *et al.* 2007; Kivity *et al.* 2019); DBT is focused on the treatment of symptoms, is more structured, and during therapy, the patient learns by practising selected skills and using them in everyday life (Lynch *et al.* 2007; Kliem *et al.* 2010; Bernheim *et al.* 2019 DeCou *et al.* 2019); MBT is based on mentalization, promotes the ability to reflect the mental state, and consequently reduces unwanted symptoms and manifestations (Laurenssen *et al.* 2014; Bateman & Fonagy, 2019; Juul *et al.* 2019). In ST, the patient learns to change their negative core beliefs and maladaptive strategies by understanding and working with schemes and modes (Giesen-Bloo *et al.* 2006; Tan *et al.* 2018).

The problem of generalization of the evidence-based results is that most psychotherapy investigations in patients with BPD exclude patients, who have comorbidities, such as substance abuse, severe eating disorders, and narcissistic and antisocial personality disorders, regardless of high success rates with BPD patients (Fassbinder *et al.* 2018). These specific groups typically continue lacking specific treatments, undergo frequent and prolonged hospitalizations, and have a low quality of life and psychosocial functioning. Clinical experience suggests that the majority of BPD patients with severe co-morbidity mentioned above only achieve frail remission, but most of them can stabilize more or less in life over time. The concept of recovery is, therefore, adequate here.

Pharmacotherapy

While specialized psychotherapy is considered first-line treatment for BPD and no medication has been approved for BPD, psychopharmaceuticals are commonly administrated. Various types of medication are used in BPD, and polypharmacy is prominent. The use of antidepressants in patients with BPD has been declining slightly, while the prescription of mood stabilizers and second-generation antipsychotics has been growing. Prescription rates for quetiapine, the most frequently used medication in BPD (22%), increased over time (Bridler *et al.* 2016). Since there is an overall agreement that little evidence of the effectiveness of psychopharmaceuticals exists for BPD, psychiatrists are either recommended to almost absolutely avoid pharmacotherapy in BPD patients or use a 'targeted' style, using the specific drug for the defined symptoms of BPD (Stoffers & Lieb 2015). This has formed some confusion in clinical practice and contributed to a diversity of prescribing practices for BPD.

Four types of medications showed efficacy in BPD –mood stabilizers, antidepressants, antipsychotics, and omega-3-unsaturated fatty acids (Paris, 2011; Stoffers & Lieb, 2015; Bozzatello *et al.* 2018). Mood stabilizers have been at least partially effective in anger and impulsivity problems (Hollander *et al.* 2005; Mercer *et al.* 2009; Reich *et al.* 2009; Starcevic & Janca, 2018; Romanowicz *et al.* 2019). However, some studies found insufficient effect (Frankenburg & Zanarini, 2002; Moen *et al.* 2012; Crawford *et al.* 2018). Antipsychotics were partially effective in reducing the intensity of transient psychotic and quasi-psychotic symptoms and cognitive disorders (Nickel *et al.* 2006; Bozzatello *et al.* 2017; O'Leary *et al.* 2018; Slotema *et al.* 2018). If depressive or anxiety spectrum disorders occur, antidepressants or anxiolytics may be indicated (Pascual *et al.* 2010; Romanowicz *et al.* 2019).

There was evidence of extensive use of medication in borderline personality disorder patients: benzodiazepines/hypnotics, antipsychotics, mood stabilizers and antidepressants, mostly with polypharmacy (Bridler *et al.* 2015; Paolini *et al.* 2017; Riffer *et al.* 2019). The most common reason for polypharmacy was the lack of symptom relief. Nevertheless, medication leads to stabilization of patients, not their full remission. An extended duration of hospitalization was associated with the administration of antipsychotic and/or antidepressant medication, while a shorter hospitalization was accompanying the prescription of a mood stabilizer (Paolini *et al.* 2017). The positive correlation between the number of drugs and the efficacy of the treatment program, as well as the lack of a relationship between the number of drugs and co-morbidity, opposes the frequently discussed iatrogenic effect of polypharmacy in BPD (Riffer *et al.* 2019).

Skills development and psychoeducation

An excellent benefit for BPD patients is learning the skills and mechanisms to help them manage both symptoms and problems they often cannot cope with (Armbrust & Ehrig, 2016; Cavelti *et al.* 2019; Mitchell

et al. 2019). These are stress-reducing techniques, adaptation strategies to stressful situations, emotional regulation, ability to reduce internal and external aggressiveness, and reduction of suicidal behaviour (Mitchell *et al.* 2019). Educating the patient and family about the prognosis and treatment approaches is essential for a better understanding of the disorder. It does not only improve the attitude of the patient but also the attitude of the family towards treatment. Patients with BPD, who understand their disorder, are better prepared to recognize problems and symptoms and it allows them to prepare and manage problems before the situation escalates, and the disease relapses fully (Jacob *et al.* 2018; Klein *et al.* 2018).

Further treatment of comorbid disorders

Co-morbid disorders in patients with BPD often occur and further complicate their life. The most common are anxiety disorders, substance abuse disorders, mood disorders, and other personality disorders (Zanarini *et al.* 1998a; Zanarini *et al.* 1998b). These comorbid disorders should be treated concomitantly with BPD. Initial treatment should be intensive, especially to cope with comorbid conditions, often in an inpatient facility, and then after discharge, outpatient care should follow (APA, 2001).

Treatment of BPD patients is possible and has better outcomes when started as soon as possible from the diagnosis of the disease. The disease is often complicated by comorbid disorders such as addiction, depression, anxiety and other possible personality disorders. There is no treatment to cure, but it is possible to stabilize the patient in the long term and work on the symptoms of the disease that are burdensome for him. Primary treatment consists of psychotherapy. There are various modalities of psychotherapy treatment of BPD. Psychiatric medication is commonly prescribed to patients, although the effect on the progression and prognosis of BPD is often not substantiated. Psychiatric medication is therefore used more for comorbid conditions, most often anxiety, depressive and for impulsivity reduction. It is important to educate the patient and his family and create an environment of mutual understanding, help and acceptance. It is advisable to practice with the patient itself the adaptive abilities to reduce the tension experienced by the patient.

(5) Patient's responsibility for their recovery

There is no known treatment method to cure BPD entirely. Regardless of the length of the asymptomatic period, relapse is always possible (Adshead, 2001). Therefore, maintaining the asymptomatic period is the best achievable goal for an individual with BPD. However, recovery can be long-term and sometimes permanent. The condition is that the patient follows his treatment program, not only for BPD, but also for other co-morbid disorders, and monitors his progress and possible signs of relapse (APA, 2006).

Clinical improvement is a remarkable achievement and an obvious goal for healthcare, but it remains unclear to what extent these achievements reflect the demands of patients themselves. Clinical improvement or risk reduction does not always coincide with patients' assessment and expectations about meaningful progress in life (Slade & Hayward, 2007; Slade *et al.* 2008). Recent findings suggest that the recovery objectives can be perceived differently by clients and healthcare providers. (Turton *et al.* 2011).

Overall, the patient's responsibility for their recovery is critical in improving their mental condition. Therefore, their positive approaches to treatment may deteriorate after finding that it is a long and usually strenuous journey. However, if the patient enters and undergoes the therapy, the symptoms of borderline psychopathology can be gradually managed and eventually eliminated. It is often a longer-term process of self-awareness and self-observation of their actions, feelings, and overall approach to the outside world. Responsibility for the recovery process is one of the right and positive signs for change and improvement in the lives of patients with BPD. Taking responsibility is also motivation to continue treatment and allows patients to take an active part in treatment.

DISCUSSION

The concept of recovery explores the possibility of treatment outcomes, standing between temporary relief and full remission, and at the same time differing from both of these extremes of therapeutic outcome. Recovery is a subjective perception that cannot be considered as a complete cure. Full remission of the disorder, which is often considered to be the best treatment outcome, and likely to have better long-term outcomes in improving the patient´s quality of life, is not always achievable for every patient. In these conditions, recovery can be viewed as an essential goal for both the patient and the therapist. Earlier adjustment to treatment results in a positive response from the patient to treatment, enhancing patient cooperation and confidence, a better understanding of their condition, and motivate them to continue treatment. Criteria for recovery in this disorder cannot be formulated separately from understanding the subjective experience of the patients themselves (Balaratnasingam & Janca, 2020).

The recovery should be the minimum goal in treating a patient. It leads to subjectively better life experience and at the same time to an objective alleviation of the symptoms accompanying the mental disorder. However, patients may differ in their perception of what is a problem for them and what their goals are, both among themselves and with the care provider. Allowing the patient to take responsibility for their treatment can increase their motivation to continue the treatment by supporting their active role in the treatment. The remission of the disorder is still the ideal

goal, but this condition may require more time, and a less distant goal can be more motivating than a distant and uncertain one.

Research suggests that BPD patients are numerous in the population and account for a high percentage of hospitalized patients in psychiatric wards. The symptoms of the disorder gradually diminish over the years. Patients can, therefore, benefit more likely from a faster condition adjustment that would reduce the adverse effects often endangering the patient's life, especially situations that lead to self-harm and suicidal behaviours.

Considering the treatment approaches, specific psychotherapies are showing to be effective. On the other hand, while some drugs, especially antipsychotics and mood stabilizers, showed limited effectivity on specific symptoms of BPD, their side effects may hamper their therapeutic benefits. Balancing the advantages and disadvantages of antipsychotic therapy in BPD may sometimes be challenging. Also, we are witnessing the abuse of psychopharmaceuticals for self-harm and suicidal behaviour in clinical practice. In this light, psychotherapy approaches seem safer and generally more effective. In addition to the regular treatment process, training in personal competencies, communication, vocational functioning, and building resilience also needs to be established.

Future research should focus on a more specific selection of patients for each selected path of psychotherapy by researching specific therapeutic processes (Doering *et al.* 2010). It is essential to develop treatment goals in collaboration with the patient and include their priorities and long-term plans. It is also essential to consider which services could be involved in this process and how they can help to meet these goals. These are specialized BPD services within the health and counselling sector, as well as other services focused on co-morbid problems, including eating disorders, drug and alcohol use, assistance to traumatized patients, or social services to help with accommodation and job search.

CONCLUSION

Many patients with BPD cannot be cured entirely, but they can achieve recovery. Recovery presents a process by which a person reaches a state where he/she can live a full and satisfying life even with some disabilities. It is an achievable goal in the treatment of individuals with BPD. The recovery focuses not only on the control of BPD symptoms but also establishing one´s own identity, the meaning of life, and improving its quality. It is based on the individual needs of the patient, arranging personal goals and strategies to achieve them, as well as systematic work on the patient's needs in the essential areas of life.

By the time the BPD patient comes into therapy, they want to find a quick solution to their problems. Therefore, their approach to treatment may deteriorate after finding that this is a long and usually strenuous journey. However, if the patient enters and undergoes the therapy, the symptoms of borderline psychopathology can be gradually managed and eventually eliminated. Stable recovery is an objective that requires maintaining long-term adaptive patterns created in the treatment and being willing to seek help in a crisis. Thus, the patient's assumption of responsibility for their recovery and maintaining their health is required for improvement. Psychotherapy, psychosocial rehabilitation, marginally also pharmacotherapy help people with BPD to improve the quality of their life and provide significant aid on their personal path to recovery.

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