Borderline personality disorder

Introduction

Borderline personality disorder is marked by difficulties in interpersonal relationships, impulsiveness, mood instability and a high rate of suicidal behaviour. These make it hugely debilitating and lead to strained relationships. The economic burden is not inconsiderable; centrally from loss of productivity and within health-care systems as a result of treatment-seeking behaviour. This article considers the aetiology, diagnosis and management of this important condition and provides important practical guidance.

Borderline personality disorder can have devastating effects on personal relationships owing to emotional lability, impulsivity as well as use of complex defence mechanisms (e.g. devaluation and idealization) to deal with difficult, often ambivalent, feelings.

The prevalence of borderline personality disorder among primary care attendees is around 5% (Moran et al, 2000) and patients with the condition are more likely to attend frequently than those without. Within mental health-care settings, the prevalence of personality disorders is as high as 50%, with borderline personality disorder the most common personality disorder outside the forensic sub-speciality (National Collaborating Centre for Mental Health, 2009). There are limited data on the economic cost of borderline personality disorder in Britain, but a Dutch study (van Asselt et al, 2007) estimated the cost as €17 000 (£14 000) per patient per year. Only a fifth of this was health-care related, the remainder included criminal justice costs and those resulting from reduced productivity.

History

Adolf Stern, the American psychoanalyst, first coined the term 'borderline' in 1938 to describe a group of patients whose condition did not easily fit into the psychotic or neurotic group of mental disorders.

In the 1960s and 1970s, Otto Kernberg recommended that mental disorders be broadly based on three separate groups of personalities: psychotic, neurotic or 'borderline personality'. A significant advance occurred in 1975 when Gunderson and Singer reviewed the literature and elicited several key features which define the disorder. As borderline personality disorder became more recognized it was incorporated into DSM-III in 1980 making it a formal psychiatric diagnosis (Friedel, 2004).

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Epidemiology

Although by its nature one would assume that borderline personality disorder occurs globally, there has been little epidemiological research into it outside Europe and North America. Coid and colleagues (2006) found that the weighted prevalence of borderline personality disorder in Britain was 0.7%. A large American study (Grant et al, 2008) suggested there was no significant gender difference in prevalence. Torgersen et al (2001) suggested that living in a city centre, the absence of a partner and a younger age were all correlates of borderline personality disorder.

Aetiology

The aetiology of borderline personality disorder remains incompletely understood and no single risk factor is responsible. A biological predisposition is probably essential to developing the condition, with environmental factors increasing the risk.

There is growing evidence that borderline personality disorder is linked to genetic abnormalities affecting neurotransmitter pathways in the brain which govern behavioural responses such as impulsiveness, emotion processing and controlling destructive urges. Abnormalities affecting the serotonergic neurotransmitter pathway through mutations in the 5-HTTLPR and tryptophan hydroxylase gene have been strongly implicated (Leichsenring et al, 2011).

Poor parenting in the form of emotional under-involvement, trauma or neglect appears to be the most important psychosocial factor. High levels of physical, sexual and emotional abuse are reported, often retrospectively (National Collaborating Centre for Mental Health, 2009).

Understanding the pathophysiology of borderline personality disorder has been greatly enhanced by functional imaging. Imaging studies have shown deficits in prefrontal cortex connectivity which correlate with the clinical observation that borderline personality disorder patients have difficulty with interpersonal skills owing to a limited ability to think ahead, empathize with others and problem solve using learnt behaviours (Nelson and Schulz, 2012).

Diagnosis

Borderline personality disorder is one of the most widely debated diagnoses among personality disorders. There is also much conjecture over the validity and reliability of the diagnosis using either the *International Classification of Diseases*, 10th Revision (ICD-10; World Health Organization, 1992) or the *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (DSM-5, American Psychiatric Association, 2013). Applying the diagnostic criteria for borderline personality disorder in the ICD and DSM to the same group of patients has shown little consistency in reaching a primary diagnosis (National Collaborating Centre for Mental Health, 2009).

Both DSM-5 and ICD-10 define personality disorders as being enduring and debilitating. Using DSM-5 borderline personality disorder is diagnosed by the presence of five out of nine criteria (*Table 1*), which are categorized under four key domains.

Borderline personality disorder is not an individual category in ICD-10 but appears as a subtype of emotionally unstable personality disorder, borderline type. *Table 2* summarizes the defining diagnostic features.

Different interview schedules are used to diagnose borderline personality disorder, but direct questioning is not always beneficial. Often, observation over a period of time and a collateral history about the patient's personality traits guides diagnosis. The absence of biological markers and overlap with other conditions can lead to diagnostic uncertainty but the chronic nature of

Table 1. Diagnostic criteria of borderline personality disorder

Affective symptoms	Affective instability as a result of marked reactivity of mood (e.g. intense episodic dysphoria, irritability or anxiety usually lasting a few hours and only rarely more than a few days)
	Chronic feelings of emptiness
	Inappropriate, intense anger or difficulty controlling anger (e.g. frequent displays of temper, constant anger, recurrent physical fights)
Interpersonal functioning	Frantic efforts to avoid real or imagined abandonment*
	A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealisation and devaluation
	Identity disturbance: markedly and persistently unstable self-image or sense of self
Impulsive control	Impulsiveness in at least two areas that are potentially self-damaging (e.g. spending, sex, substance abuse, reckless driving, binge eating)*
	Recurrent suicidal behaviour, gestures or threats, or self-mutilating behaviour
Cognitive	Transient, stress-related paranoid ideation or severe dissociative symptoms

As per DSM-5 these criteria are categorised into four domains based on those suggested by Biskin and Paris (2012). *This should not include suicidal or self-mutilating behaviour which is covered in a separate criterion

symptoms, age of onset in adolescence or early adulthood and symptoms spread across multiple domains (*Table 1*) all point towards a positive diagnosis (Biskin and Paris, 2012).

There has been much criticism of the current categorical model (the patient either has the condition or not) of diagnosing personality disorders, because rigid inclusion criteria do not always fit patients' symptoms and there can be considerable overlap among personality disorders (Sellbom et al, 2014). In terms of borderline personality disorder, the arbitrary choice of five out of nine criteria being inclusive for the diagnosis in the DSM has meant that there are 256 possible combinations of symptoms that can lead to a positive diagnosis, resulting in considerable heterogeneity. These criticisms have led to a more fluid dimensional model of diagnosing personality disorders being developed in which personality traits guide diagnosis. Although not used in DSM-5, such a model may be used in ICD-11.

Table 2. Diagnostic features of emotionally unstable personality disorder, borderline type

Emotional instability
Chronic feelings of emptiness
Disturbed or unclear aims, internal preferences and perception of oneself
Involvement in unstable relationships which may cause repeated emotional crises and be associated with excessive efforts to avoid abandonment as well as suicidal and self-harming behaviour

Borderline personality disorder is often comorbid with mood disorders, anxiety, substance misuse and post-traumatic stress disorder (Leichsenring et al, 2011). The presence of a pre-existing mental illness does not preclude someone from having borderline personality disorder and vice versa.

Treatment

There is no specific pharmacological treatment for borderline personality disorder (National Institute for Health and Care Excellence, 2009) regardless of the symptoms and behaviour shown by the patient. However, in practice, certainly in part as a result of treatment-seeking behaviour and the similarity of certain features to affective and psychotic disorders, patients receive antidepressants, mood stabilizers and antipsychotics. Pharmacological therapies may be initiated incorrectly during crises, when this period is often self-resolving irrespective of drug treatment. The evidence for pharmacotherapy in borderline personality disorder is equivocal at best (Leichsenring et al, 2011) although the side-effect profiles of psychotropic drugs are well documented, e.g. the weight gain caused by antipsychotics and teratogenicity associated with sodium valproate. Undoubtedly, borderline personality disorder patients with comorbid disorders need to be treated with psychotropic medications as indicated for that condition although the National Institute for Health and Care Excellence recommends reviewing the diagnoses especially if they were made at the time of crisis.

Psychotherapy, with a strong evidence base, remains the mainstay of management and various forms have been developed to address the specific needs of patients with borderline personality disorder. Dialectical behaviour therapy, developed by Marsha Linehan, tackles suicidal and self-harm behaviour while mentalization behaviour therapy, developed by Peter Fongey and Anthony Bateman, focuses on the patient's difficulty in considering other people's mental states. Otto Kernberg's transference-focused psychotherapy addresses early dysfunctional relationships that the patient has internalized, and schema-focused therapy, from Jeffrey Young, centres on pervasive patterns of thinking and behaving that are often deeply ingrained in borderline personality disorder (Nelson and Shulz, 2012).

An experienced psychologist or psychiatrist should decide on a suitable psychotherapy, e.g. the National Institute for Health and Care Excellence recommends dialectical behaviour therapy for women with self-harming intent. Psychotherapy should take place twice weekly for at least 3 months (National Institute for Health and Care Excellence, 2009). The holistic outcome of treatment should be monitored based on drug and alcohol use, self-harm behaviour, mood and severity of borderline personality disorder symptoms. Unfortunately, in practice, generic rather than specific psychotherapies are used in the NHS because of the limited number of staff able to deliver them (National Collaborating Centre for Mental Health, 2009).

Dealing with patients with borderline personality disorder

Patients often see a diagnosis of borderline personality disorder as a label and associated with stigma. This need not be the case – acting in an empathetic, non-judgemental and supportive manner can help alleviate this, leading to a better therapeutic alliance. Clinicians need to explain the diagnosis clearly and transparently to reduce stigma felt by the patient and to help avoid misdiagnosis and incorrect treatment of different conditions later (Biskin and Paris, 2012).

It has been noted that borderline personality disorder patients 'split' teams. Their behaviour may facilitate their notion that one team member is good while another is bad, e.g. by sharing information with certain members of staff and not others and

by commenting on perceived errors of certain staff members to other ones. This can lead to friction among teams. Awareness of this combined with effective communication within the team can help prevent it.

When faced with a patient in crisis, it is necessary to manage the situation calmly, remain empathetic and help the patient consider solutions. Short-term pharmacological treatment, e.g. sedatives, can be started to help calm the patient but should have a limited side-effect profile, minimal potential for abuse and be relatively safe in overdose. There is no indication for starting psychotropic medications during crises. Early review (within a week) after a crisis is indicated with the aim of stopping medications started acutely and evaluating overall management including any ongoing psychological intervention (National Institute for Health and Care Excellence, 2009).

Mental capacity issues

Self-harm and suicidal behaviour are common among patients with borderline personality disorder. This leads to hospital attendances where patients require treatments for the consequences of their self-injurious behaviour, e.g. antidotes to drug overdoses or managing physical injuries. When patients refuse treatment, an ethical dilemma arises for the team. Such patients require a thorough capacity assessment by the team proposing the treatment.

Verbal and written information should be provided in an understandable and supportive manner to optimize the patient's capacity to make decisions. Patients who lack capacity can be treated under common law in their best interests. However, those with capacity cannot be treated for physical illnesses under the Mental Health Act as this only relates to mental disorders. Jacob et al (2005) suggest the initial decision to refuse treatment even in those deemed to have capacity should not be regarded as final as they may actually, given they have reached hospital in the first place, be ambivalent about treatment. A concerted but not coercive effort needs to be made to help them reach a valid decision. Legal advice should be sought for patients with capacity refusing treatment. Psychiatry services should be contacted to review a self-harming or suicidal patient although it is not necessary to wait for them to address the issues surrounding capacity and initiate medical treatment.

Prognosis

Zanarini et al (2003) showed that at least half of all patients who received input from psychiatric services improved such that they no longer met diagnostic criteria for borderline personality disorder 10 years later. However, it is difficult to tell whether alleviation of features is the result of treatment or a natural time course in which individuals reflect and have a greater ability to deal with their emotions (National Collaborating Centre for Mental Health, 2009). The prognosis is better than many clinicians believe.

Final words

There is a huge scope for future research to further our understanding of this economically burdensome, hugely debilitating condition. The aetiology is certain to have genetic and environmental components. There has been much discussion about moving from a categorical diagnosis model to a more dimensional one based on personality traits, yet there is limited research to know whether this would be more effective in capturing what borderline personality disorder fundamentally is. The mainstay of treatment revolves around psychotherapy although a stronger evidence base could encourage the use of pharmacotherapy. **BJHM**

KEY POINTS

- Borderline personality disorder is a common mental disorder characterized by impulsiveness, mood instability and difficulties in interpersonal relationships.
- Borderline personality disorder is associated with high rates of self-harm and suicidal behaviour.
- There is considerable overlap between borderline personality disorder and other mental disorders such as mood disorders, post-traumatic stress disorder and substance misuse. These disorders can co-exist.
- The aetiology of borderline personality disorder is incompletely understood but genetic abnormalities in neurotransmitter pathways and environmental factors such as poor parenting play a role.
- The categorical models in *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition and *International Classification of Diseases*, 10th Revision are used to diagnose borderline personality disorder.
- Pharmacological therapy is not indicated in borderline personality disorder, with psychological interventions being the mainstay of treatment.
- There is a better prognosis than widely believed.

Conflict of interest: none.

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