The Practitioner®

Borderline personality disorder often goes undetected

Jordanova V, Rossin P. Borderline personality disorder often goes undetected.
Practitioner 2010; 254 (1729): 23-26

Dr Vesna Jordanova
MD MSc MRCPsych
Lecturer in general adult psychiatry, Imperial College, London

Dr Paola Rossin
MD
Staff grade psychiatrist, Central and North West London NHS Trust

Practitioner
Medical Publishing Ltd

©Practitioner Medical Publishing Ltd.
Reprint orders to *The Practitioner*, 10 Fernthorpe Road, London SW16 6DR, United Kingdom. Telephone: +44 (0)20 8677 3508
www.thepractitioner.co.uk

Borderline personality disorder often goes undetected

AUTHORS
Dr Vesna Jordanova
MD MSc MRCPsych
Lecturer in general adult psychiatry, Imperial College, London

Dr Paola Rossin
MD
Staff grade psychiatrist, Central and North West London NHS Trust



How do patients present in primary care?

BORDERLINE PERSONALITY DISORDER (BPD) IS A COMPLEX MENTAL DISORDER CHARACTERISED BY MOOD instability, impulsivity, relationship difficulties and disturbed self-image. There is a pervasive pattern of emotional instability, impulsive aggression, repeated self-harm and chronic suicidal tendencies often associated with suicide attempts. The disorder is associated with significant impairment of psychological, social and occupational functioning with a suicide rate of almost 10%, a rate 50 times higher than in the general population.[1]

BPD is a highly heterogeneous condition; the extent of the emotional and behavioural problems varies considerably. Some people with BPD are able to sustain a certain level of social and occupational functioning, while others experience a very high level of emotional distress. There is often rapid fluctuation from periods of confidence to despair, with fear of abandonment and rejection, often escalating in crises with impulsive aggression and self-harm. Psychiatric comorbidity is very common in BPD, including other types of personality disorder and alcohol and drug misuse.[1]

How is the condition diagnosed?

There is a striking difference between its reported prevalence in the community (1%) and its prevalence in clinical settings (10% of individuals in outpatient psychiatric clinics and 25% of psychiatric inpatients), which indicates that a large proportion of those affected with this condition are unrecognised and untreated. In primary care, the prevalence of BPD ranges from 4 to 6% of attenders.[2] Women present to psychiatric services more often than men; the gender ratio is 3:1. Most people show symptoms in late adolescence or early adult life, although some may not come to the attention of psychiatric services until much later. Individuals with BPD sometimes present through the criminal justice system.

Psychoanalysts hypothesised a delay in normal psychological development, with difficulties in integrating ambivalent feelings originally aroused against a parental figure, but later manifested in other close relationships.[3] »

Which patients should be referred?

The primitive defence mechanisms occurring in early childhood persist into adulthood. The new evidence indicates that BPD is not entirely related to environmental factors. A recent study of more than 40 twin pairs showed high heritability in BPD.[4] One common denominator of BPD appears to be dysfunctional regulation of emotions with high sensitivity to emotional stimuli, high emotional intensity, and slow return of emotional arousal to baseline.[5] Neurotransmitters have been implicated in the regulation of impulses, aggression and affect. Serotonin has been the most extensively studied of these, and it has been shown that there is an inverse relationship between serotonin levels and aggression.

BPD has attracted unfavourable descriptions; this has discouraged better understanding of this condition, and has created a stigma. Houk described BPD sufferers as 'intractable, unruly patients who used hospitals to escape from responsibilities'.[6] A UK survey of 173 psychiatrists showed that patients with BPD are perceived as 'more difficult, attention-seeking, annoying and less deserving of care'.[7] And yet, contrary to preconceived expectations, longitudinal studies have found that BPD has a good long-term prognosis.[8,9]

PRESENTATION IN PRIMARY CARE

Two specimen case histories are shown below. Patients with BPD present at times of crisis, often following an episode of self-harm. Presentation is accompanied by a sense of urgency and anxiety, demanding immediate action by the GP. In times of crisis people with BPD use primitive defence mechanisms, such as splitting and projections. The phenomenon of splitting signifies an inability to reconcile alternative or opposing perceptions or feelings within the self or others. In clinical settings, this phenomenon may be evident in patients' polarised views of others as either idealised (i.e. all good) or devalued (i.e. all bad). Projection is the mechanism whereby one projects one's own undesirable thoughts, motivations, desires, and feelings onto someone else.

Patients have marked difficulty differentiating reality from fantasy, so health problems may be perceived as life threatening. This may result in a loss of perspective and miscommunication with the GP. They may be inclined to mistrust doctors because of previous negative experiences with carers representing parental figures. Some patients may have the unconscious need to suffer in order to expiate guilty feelings. Patients often tend to idealise any new relationship with a doctor, only to switch to feelings of denigration later, seeing themselves as neglected, rejected and abandoned to struggle with their health problems alone.

The doctor should:

- create a sense of containment by staying calm and professional
- provide very clear information to counter any elaborate fantasies about their illness
- avoid encouraging the patient to idealise them
- resist being drawn into the patient's tendencies for splitting
- not retaliate by leaving the patient to a self-fulfilling prophecy of abandonment

MAKING THE DIAGNOSIS

Patients with suspected BPD should be referred to a psychiatrist for assessment and diagnosis. The diagnosis is made after obtaining a full history, mental state examination and maximum collateral history. Diagnosis is based on ICD-10 diagnostic criteria,[10] see table 1, p25, and should take into account the following:

- social and occupational functioning
- relationship history
- coping strategies, strengths and vulnerabilities
- psychiatric comorbidity
- the need for psychological treatment, social care and support
- the needs of any dependent children
- level of risk to self and others

Risk assessment is particularly important in BPD and should include consideration of the following:

- possible triggers
- differentiation between acute and chronic risk
- is the risk general or specific?
- use of drugs and/or alcohol
- previous suicide attempts
- degree of planning

Criteria for referral to psychiatric services are listed in table 2, p25.

TREATMENT

Management of BPD is particularly challenging because patients have a tendency to leave psychotherapy prematurely, regress after making progress in treatment, and engender strong counter-transference feelings in those involved in their care. The principles for the management of BPD are listed in table 3, p25.

Psychological treatment

The evidence base for the effectiveness of psychotherapies for BPD is at an early stage of development. The current evidence indicates that four types of psychotherapy are effective in treating BPD.[11-14] Two forms of treatment are viewed as psychodynamic in nature, and two are considered to be cognitive behavioural. NICE recommends against

Case 1

Mr W is 32, single and unemployed. He is introverted and socially isolated.

Presenting complaint	Insomnia and depression
Physical history	Myalgia and arthralgia
Psychiatric history	● Depression at age 16 and 28 ● Difficult relationships with family and friends ● Violence (physical and verbal) since age 15 ● Suicide attempts (i.e. jumping in front of a train and from a three-storey building)
Medication	Citalopram 20 mg for 5 months. (Before then he was on venlafaxine 150 mg with little/no benefit for 3 years)

Case 2

Ms B is 48 and unemployed. She lives alone and has an 18-year-old son.

Presenting complaint	Depression and suicidal ideation, visibly restless and agitated
Physical history	Hepatitis C, arthritis
Psychiatric history	● Depression ● Drug addiction (for 20 years, clean for past 4 years) ● Eating disorder- since a teenager ● Suicidal threats and behaviour (i.e. numerous ODs) ● Anxiety, agoraphobia, claustrophobia, panic attacks
Medication	Painkillers PRN

Table 1

ICD-10 diagnostic guidelines relating to BPD

Conditions not directly attributable to gross brain damage or disease, or to another psychiatric disorder, meeting the following criteria:

- markedly disharmonious attitudes and behaviour, involving usually several areas of functioning, e.g. affectivity, arousal, impulse control, ways of perceiving and thinking, and style of relating to others
- the abnormal behaviour pattern is enduring, long standing, and not limited to episodes of mental illness
- the abnormal behaviour pattern is pervasive and clearly maladaptive to a broad range of personal and social situations
- the above manifestations always appear during childhood or adolescence and continue into adulthood
- the disorder leads to considerable personal distress but this may only become apparent late in its course
- the disorder is usually, but not invariably, associated with significant problems in occupational and social performance.

For a diagnosis of BPD clear evidence is usually required of the presence of at least three of the traits or behaviours given in the clinical description.

Table 2

Who should be referred to psychiatric services?

A person presenting in primary care who has repeatedly self-harmed or shown marked emotional instability and risk-taking behaviour

A person with diagnosed BPD who is in crisis when:

- levels of distress and risk to self or others are increasing
- levels of distress and risks have not subsided despite treatments

Table 3

Key principles for the management of BPD

- Use evidence-based treatments
- Develop an optimistic and trusting relationship
- Realistic expectations of therapies
- Active participation (recommendation not persuasion)
- Stop rather than start medication
- Avoid hospital treatments
- Differentiate chronic and acute risks
- Manage endings and support transitions
- Involve families and carers

the use of brief psychological interventions (less than 3 months duration) for BPD.[15]

The choice of psychological intervention should be based on the following patient characteristics:

- preference
- degree of severity of BPD
- motivation to change
- willingness to commit to psychotherapy
- ability to maintain psychotherapeutic boundaries

plus

- the availability of social and professional support

Psychodynamic therapies: Mentalisation based treatment (MBT) aims to improve the patient's skills in identifying his or her feelings and thoughts and those of other people as well.[11] The concept is based on the idea that difficulty in mentalisation is caused by difficulties in early attachments. The longitudinal evidence is that MBT is associated with better clinical outcomes in BPD.[16]

Transference-focused psychotherapy (TFP) is based on Kernberg's concept that excessive early aggression has led the young person to split his or her positive and negative images of him- or herself and others.[12] The primary goal of TFP is to reduce symptoms and self-destructive behaviour through the modification of representation of self and others. Primary techniques are clarification, confrontation and interpretation of transference. TFP is associated with decrease in irritability, impulsivity and suicidality.[17]

Cognitive behaviour therapies: Dialectical behaviour therapy (DBT) has suggested that the core problem of people with BPD is emotional dysregulation that triggers impulsivity and relationship difficulties.[13] DBT consists of skills groups, individual therapy, and phone coaching for patients. Clinical trials show that DBT results in a significant reduction in suicidal behaviour and fewer hospital admissions.[18]

Schema-focused therapy (SFT) is based on work by Young.[14]

Patients with BPD are thought to have four dysfunctional life schemas:

- detached protector
- punitive parent
- abandoned/abused child
- angry/impulsive child

Change is achieved through a range of behavioural, cognitive and experimental techniques. SFT is associated with clinically significant improvements in psychopathology and quality of life.[19]

Pharmacological treatment

The current evidence from randomised controlled trials does not support effectiveness of drug treatments for overall severity of BPD; antidepressants are not effective for affective dysregulation, nor can low-dose antipsychotics be advised for managing cognitive-perceptual symptoms.[20] The evidence supports the use of mood stabilisers as first-line treatments of affective symptoms. There is no evidence of benefit with polypharmacy, which should be avoided.

NICE recommends that drug treatment should not be used specifically for BPD or for individual symptoms associated with the disorder. Drug treatments should be considered in the management of comorbid conditions. For example, antidepressants may be considered if there is evidence of clear-cut depression. Short-term use of sedatives may be considered cautiously for people in a crisis, but the duration of treatment should be no longer than one week. People with BPD who do not have any comorbid disorder should be reviewed with the aim of reducing and stopping any unnecessary drug treatment.

MONITORING

The care and monitoring of patients with BPD should be tailored on the basis of individual needs and level of risk, which may involve primary, secondary or tertiary care. A number of service models have been developed in recent decades.[21]

Deciding the appropriate level of support involves consideration of a number of factors, including the:

- range and complexity of the patient's needs
- risk of harm posed to self and others
- extent of involvement with other statutory and non-statutory agencies.

Hospital admissions are not helpful; often they result in deterioration of the patient's condition, and should be seen as a last resort intervention to prevent suicide. »

key points

SELECTED BY

Dr Peter Saul
GP, Wrexham and associate GP Dean for North Wales

Borderline personality disorder (BPD) is a complex mental disorder characterised by mood instability, impulsivity, relationship difficulties and disturbed self-image. There is a pervasive pattern of emotional instability, impulsive aggression, repeated self-harm and chronic suicidal tendencies often associated with suicide attempts. Some patients are able to sustain a certain level of social and occupational functioning, while others experience a very high level of emotional distress. There is often rapid fluctuation from periods of confidence to despair.

A large proportion of those affected with this condition are unrecognised and untreated. Women present to services three times more often than men. Most people show symptoms in late adolescence or early adult life. BPD is not entirely related to environmental factors. A study of more than 40 twin pairs showed high heritability.

One common denominator of BPD appears to be dysfunctional regulation of emotions. Patients with BPD are perceived as 'more difficult, attention-seeking, annoying and less deserving of care'. People with BPD present at times of crisis, often following an episode of self-harm. Presentation is accompanied by a sense of urgency and anxiety. Persons with BPD have marked difficulty differentiating reality from fantasy, so that health problems may be perceived as life threatening. This may result in loss of perspective and miscommunication with the GP. The doctor should provide very clear information to counter any elaborate fantasies about their illness.

Patients with suspected BPD should be referred to a psychiatrist for assessment and diagnosis. The diagnosis is made after obtaining a full history, mental state examination and maximum collateral history. Risk assessment is particularly important in BPD.

Four types of psychotherapy are effective in treating BPD: mentalisation-based treatment; transference-focused psychotherapy; dialectical behavioural therapy; and schema-focused therapy.

Antidepressants are not effective for affective dysregulation, nor can low-dose antipsychotics be advised for managing cognitive-perceptual symptoms. The evidence supports the use of mood stabilisers as first-line treatments of affective symptoms. Drug treatment should be considered for comorbid conditions.

NICE recommends that community mental health services (secondary care) should be responsible for the treatment and management of people with BPD, hospital admissions are not helpful. GPs play a crucial role in identifying patients who may be suffering from BPD, in referring them to CMH services or specialist teams if available in the area, and in providing continuity of care for patients with milder forms of BPD or patients who are in a more stable condition.

NICE recommends that community mental health (CMH) services (secondary care) should be responsible for the treatment and management of people with BPD. There are also specialist multidisciplinary teams (tertiary care) for people with personality disorders with specific expertise in the diagnosis and management of BPD. These teams provide assessment and treatment of patients with complex needs and/or high levels of risk, and also provide consultation and advice to primary and general psychiatric services.

There is currently a great flourishing of community-based organisations related to mental health services and independent organisations, some involving former service users (e.g. Borderline UK), which are structured to support patients with personality disorder with learning or vocational interventions, according to the model of social inclusion.

CONCLUSION

GPs play a crucial role in identifying patients who may be suffering from BPD, in referring them to CMH services or specialist teams if available in the area, and in providing continuity of care for patients with milder forms of BPD or patients who are in a more stable condition. It is fundamental that all practitioners caring for patients with BPD work together in order to understand needs and risks and to provide patients with consistent support and help.

REFERENCES

1 Skodol A, Gunderson J. The borderline diagnosis I: psychopathology, comorbidity, and personality structure. *Biol Psychiatry* 2002; 51: 936–95
2 Moran P, Jenkins R, Tylee A, et al. The prevalence of personality disorder amongst UK primary care attenders. *Acta Psych Scand* 2000; 101: 1-6
3 Kernberg O. Borderline personality organisation. *J Am Psychoanalytic Ass* 1967; 15: 641-85
4 Torgersen S, Lygren S et al. A twin study of personality disorders. *Compr Psychiatry* 2000; 41: 416–25
5 Herpertz SC, Dietrich TM et al. Evidence of abnormal amygdala functioning in borderline personality disorder: a functional MRI study. *Biol Psychiatry* 2001; 50: 292–8
6 Houck JH. The intractable female patient. *Am J Psychiatry* 1991; 148: 967-75
7 Lewis G, Appleby L. Personality disorder: the patients psychiatrists dislike. *Br J Psychiatry* 153: 44-49 (1988)
8 Zanarini M, Frankenburg F, Hennen J et al. The longitudinal course of borderline psychopathology: 6-year prospective follow-up of the phenomenology of borderline personality disorder. *Am J Psychiatry* 2003; 160: 274-83
9 Zanarini M, Frankenburg F, Reich D et al. The subsyndromal phenomenology of borderline personality disorder: a 10-year follow-up study. *Am J Psychiatry* 2007; 164: 929-35
10 World Health Organization. The ICD-10 Classification of Mental and Behavioural Disorders. WHO. Geneva. 1992
11 Bateman A, Fonagy P. Psychotherapy for borderline personality disorder: mentalisation-based treatment. Oxford University Press. New York. 2004
12 Kernberg O, Selzer M, Koeningsberg N et al. Psychodynamic psychotherapy of borderline patients. Basic Books. New York. 1989
13 Linehan M. Cognitive-behavioural treatment of borderline personality disorder. Guilford Press. New York. 1993
14 Young J, Klosko J, Weshaar M. Schema therapy: a practitioners guide. Guilford Press. New York. 2003
15 National Institute for Health and Clinical Excellence. Borderline personality disorder: treatment and management. CG78. NICE. London. 2009
16 Bateman A, Fonagy P. 8-year follow-up of patients treated for borderline personality disorder: mentalisation-based treatment versus treatment as usual. *Am J Psychiatry* 2008; 165:631-8
17 Clarkin J, Levy K, Lenzenweger M et al. Evaluating three treatments for borderline personality disorder: a multiwave study. *Am J Psychiatry* 2007; 164: 922-8
18 Linehan M, Comtois K, Murray A et al. Two-year randomized controlled trial and follow-up of dialectical behavioural therapy vs therapy by experts for suicidal behaviours and borderline personality disorder. *Arch Gen Psychiatry* 2006; 63: 757-66
19 Giesen-Bloo J, van Dyck R, Spinhoven S et al. Outpatient psychotherapy for borderline personality disorder: randomized trial of schema-focused therapy vs. transference-focused psychotherapy. *Arch Gen Psychiatry* 2006; 63: 649-58
20 Lieb K, Volim B, Rucker G et al. Pharmacotherapy for borderline personality disorder: Cochrane systematic review of randomized trials. *Br J Psychiatry* 2010; 196: 4-12
21 Bateman A, Tyrer P. Services for personality disorder: organisation for inclusion. *Adv Psych Treat* 2004; 10: 425-33

Useful information

www.personalitydisorder.org.uk provides information on geographical distribution of specialist services for personality disorders across the UK

www.emergenceplus.org.uk Borderline UK is a national user-led network of people who meet the criteria for, or who have been diagnosed with, borderline personality disorder

Tell us what you think?

If you would like to comment on this article or ask the authors a question, write to:
editor@thepractitioner.co.uk