key points

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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.