BORDERLINE PERSONALITY DISORDER: A PRACTICAL REVIEW

Borderline personality disorder is a challenging condition both to understand and treat. Symptoms can be remembered by using the mnemonic "PRAISE", where each letter indicates one or more of the nine defining symptoms.

By Mark J. Berber, MB, MRC Psych, FRCPC

Dr. Berber is staff psychiatrist, Markham-Stouffville Hospital, Markham, Ontario. He received his medical degree in 1979 from Trinity College, Dublin, Ireland. He became a member of the Royal College of General Practitioners in London, England in 1983, a member of the Royal College of Psychiatrists in London in 1985, and a fellow of the Royal College of Physicians in Canada in 1989.

Borderline personality disorder (BPD) is defined as a pattern of unstable interpersonal relationships, self image and moods and marked impulsivity. The disorder begins in early adulthood and is indicated by the presence of at least five of nine symptoms.[1] Symptoms can be remembered by using the mnemonic *PRAISE*, where each letter indicates one or more of the nine defining symptoms (Table 1).

PARANOID IDEATION

During periods of extreme stress, transient paranoid ideas or dissociative symptoms (depersonalization and derealization) may occur. Depersonalization is a feeling of personal unreality—a feeling of detachment from one's body (as if looking at it from outside). A suitable screening question is: "Do you ever have the feeling that you are unreal?" In derealization, instead of experiencing oneself as unreal, the patient feels that the world is unreal. People and objects seem artificial, flat and dull. A suitable screening question is: "Do you ever feel that the world around you is unreal?"

RELATIONSHIPS

Individuals with BPD have unstable and intense relationships. Patients tend to pigeonhole people into "all good" and "all bad" camps, unable to appreciate that most people, including the self, possess good and bad qualities simultaneously. Patients often idealize others, especially therapists, as caring and supportive but can suddenly switch and consider them cruel and punitive, especially if

TABLE 1

SYMPTOMS OF BORDERLINE PERSONALITY DISORDER

Paranoid ideation or dissociative symptoms
Relationships—intense and unstable
Abandonment—fear of
Anger—inappropriate and intense
Affect—unstable
Impulsivity
Identity disturbance
Suicidal behavior
Emptiness—chronic feelings

Adapted from: American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*. Fourth Edition. American Psychiatric Association Press, Washington, 1994.

needs are not met. This process is known as "splitting", a defense (or coping) mechanism often used by these patients. Defense mechanisms are automatic psychologic processes that protect the patient against anxiety and awareness of internal and external stressors.

ABANDONMENT

Individuals with BPD make frantic efforts to avoid real or imagined abandonment. When faced with a realistic time-limited separation, the individual experiences intense abandonment fears and inappropriate anger (*e.g.*, when the clinician announces the end of the hour). The perception of rejection can lead to profound changes in self image, mood and behavior. The abandonment fears are usually related to an intolerance of being alone and may lead to impulsive self harm.

ANGER

Individuals with BPD often express inappropriate and intense anger or have difficulty controlling their anger. These people may be sarcastic, bitter or display verbal outbursts. The anger is often triggered when a caregiver or lover is considered to be uncaring, abandoning or withholding. Such expressions of anger are often followed by shame and guilt.

AFFECT

Affective (or mood) instability is a hallmark of BPD, with mood being extremely sensitive to changes in the environment. Unlike patients with major depression who have persistent neurovegetative symptoms, mood varies greatly from day to day or during the course of the day. The basic dysphoric mood is often disrupted by anger, panic and despair and is rarely relieved by periods of well-being or satisfaction.

IMPULSIVITY

Impulsivity may occur in at least two potentially self-damaging areas. Individuals may gamble, spend money irresponsibly, binge eat, abuse substances, engage in unsafe sex or drive recklessly.

IDENTITY DISTURBANCE

The identity disturbance seen in BPD is characterized by persistent, unstable self image or sense of self. Goals, values, preferred friends, sexual orientation and career plans may change suddenly and dramatically.

SUICIDAL BEHAVIOR

Completed suicide occurs in 8% to 10% of individuals with BPD and self-mutilative acts (*e.g.*, cutting or burning) and suicide threats and attempts are very common.[1]

EMPTINESS

Individuals with BPD are troubled by chronic feelings of emptiness. They are easily bored and constantly seek something to do.

HOW MANY PEOPLE ARE AFFECTED BY BORDERLINE PERSONALITY DISORDER?

BPD occurs in about 2% to 3% of the general population and is by far the most common personality disorder in clinical settings.[2] It occurs in 11% of patients seen in outpatient mental-health clinics and in 19% of psychiatric inpatients.[2] BPD appears to occur about three times more often in women than in men. It is approximately five times more common among first-degree relatives of those with the disorder than in the general population. There is also an increased familial risk of substance abuse, antisocial personality disorder and depressive disorders.[2]

WHAT CAUSES BORDERLINE PERSONALITY DISORDER?

BPD develops as a result of several interacting risk factors: hereditary, neurologic and environmental.

Inheritance can play a role? Although there is little support for the genetic transmission of BPD, there is evidence supporting the inheritance of some of the traits found in borderline patients.[3] The heritability of most personality traits, including impulsivity and affective lability, is close to 50% and the presence of these traits may increase the vulnerability of the individual to other risk factors.[4]

The environment's role. Environmental risk factors that increase the risk of developing BPD include childhood sexual and physical abuse, emotional withdrawal or neglect, parental inconsistency and witnessing of domestic violence.

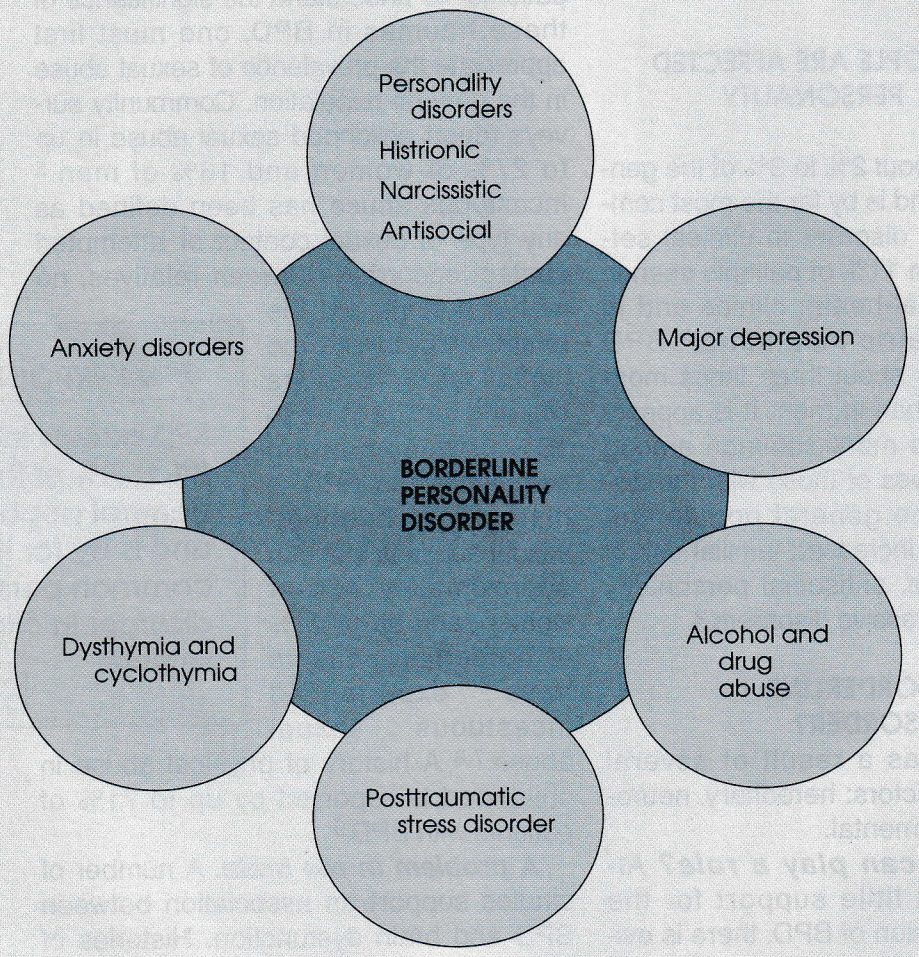
Childhood sexual abuse and incest are often found in the histories of borderline patients. To understand the significance of these traumas in BPD, one must first appreciate the prevalence of sexual abuse in the general population. Community surveys report childhood sexual abuse in up to 27% of women and 16% of men.[5] Incestuous abuse has been defined as any type of sexual contact or attempted contact occurring between relatives, no matter how distant the relationship, before the victim turns 18 years old, and occurs in up to 16% of women in the community.[6] In BPD, a history of childhood sexual abuse is found in approximately 70% of women, and up to 41% of borderline patients have experienced incestuous sexual abuse.[7,8] A history of physical abuse in childhood is reported by up to 71% of patients with BPD.[9]

KEYPOINT

BPD occurs in about 2% to 3% of the general population and is by far the most common personality disorder in clinical settings.

A problem in the brain. A number of studies support an association between BPD and brain dysfunction. Histories of developmental delay (*e.g.,* learning disability) and acquired brain injury have been reported in borderline patients, but overall, the findings are inconclusive. Electroencephalogram abnormalities have also been reported in patients with BPD, but not all studies have confirmed this finding. Neuropsychologic test results suggest orbital-frontal system dysfunction consistent with impulsivity and affective lability. Reduced central serotonergic function has also been pos-

FIGURE 1
BORDERLINE PERSONALITY DISORDER AND COMORBID CONDITIONS



tulated as a cause for many of the symptoms seen in BPD.[10]

COMORBIDITY

Symptoms of BPD often overlap with symptoms of the other personality disorders belonging to the dramatic cluster (*i.e.,* histrionic, narcissistic and antisocial). Comorbid Axis I diagnoses include major depression (40%), posttraumatic stress disorder (34%) and alcohol dependence (27%) (Figure 1).[11]

TREATMENT CAN BE A CHALLENGE

Patients with BPD are among the most challenging patients to treat, often evoking a strong emotional response in the treater. There is no "treatment of choice" for BPD, but therapy usually involves psychotherapy with or without medica-

tion. The efficacy of treatment often reflects the "chemistry" between the patient and therapist rather than the treatment itself.

SUPPORTIVE AND DYNAMIC THERAPIES: FINDING A BALANCE

Most patients with BPD are now treated with a combination of supportive and dynamic therapies.[12]

In "supportive" therapy the therapist offers hope and reassurance, encourages the therapeutic alliance, educates the patient and, sometimes, prescribes medication. These supportive techniques can be utilized by family physicians and do not require psychodynamic training and expertise.

Dynamic therapy (also known as "expressive", "exploratory" and "intensive" psychotherapy) includes supportive and interpretive techniques and closer examination reveals that dynamic and supportive therapies have many similarities. Most clinicians agree that there are several essential requirements of the therapist for the effective psychotherapy of borderline patients (Table 2).[13] Psychotherapy is usually provided on a once-weekly basis, with sessions lasting from 20 to 45 minutes. Many patients are improved by six months but most require support during periods of difficulty over the years. Through this prescription of intermittent continuous therapy, the patient is reassured that during periods of conflict or stress, help will be available.[14]

Relationship management stresses the importance of recognizing the patient as a responsible, competent adult. The therapist is considered a "facilitator", encouraging the patient to define and address his or her problems.[15]

TABLE 2

ESSENTIAL REQUIREMENTS IN THE TREATMENT OF BORDERLINE PERSONALITY DISORDER

Establish regular appointments
Provide feedback to the patient
Help patients become aware of the negative consequences of self-destructive behaviors
Help patients understand how thoughts and feelings determine their actions
Discourage behavior that threatens the safety of the patient, the therapist or the therapy
Focus on the present rather than the past, especially early in treatment
Monitor one's own emotional reactions to the patient

Adapted from Waldinger RJ: Intensive psychodynamic therapy with borderline patients: An overview. Am J Psychiatry 1987; 144:267-74.

Dialectic behavior therapy is a form of cognitive behavioral treatment that has been specifically developed to treat BPD. Therapists help the patient extinguish unhealthy behaviors (*e.g.*, suicidal gestures, alcohol abuse) and teach the patient new behavioral and coping skills. Once-weekly individual therapy is complemented by structured "skills training," provided in a group-therapy setting.[16]

Therapists who are enthusiastic and who clearly convey their sincerity and interest in understanding their patients will have the best results. Such therapists can also afford an occasional mistake because their patients will continue to respect their sincerity and efforts.

WHAT SHOULD I PRESCRIBE?

There have been a limited number of studies using small numbers of patients to examine the effects of medication on borderline patients. Responses are not

as predictable as those seen with Axis I disorders, and we must await further studies before firm conclusions can be made. When using a target-symptom approach, however, medications have helped to alleviate many of the symptoms characteristic of BPD.

Impulsivity/behavioral dyscontrol (*e.g.*, angry outbursts, self-damaging acts and suicidal attempts) can be reduced by using carbamazepine (can also help to control irritability and mood swings).[17] Impulsivity has also been relieved by lithium carbonate, but further studies are needed and the risk of lethality with lithium overdose limits the use of this agent in chaotic patients.[18] Low-dose, high-potency neuroleptic agents have been reported to modestly reduce impulsive aggressive behavior.[19]

Depression in BPD should not be treated with tricyclic anti-depressants (TCAs), as these agents often make symptoms worse.[20] TCAs are also extremely toxic when taken as an overdose. The MAOIs have proved helpful in relieving depression and affective lability but carry risks associated with overdose, dietary restrictions and drug interactions.[21] Selective serotonin reuptake inhibitors (SSRIs) are safe alternatives and have proved effective not only in alleviating depression but also in reducing impulsivity, aggression and self-destructive behaviors.[22,23]

Anxiety may be relieved by benzodiazepines, but these agents—when used in borderline patients—have been reported to disinhibit anger and impulsive behavior.[24] Risk of abuse, tolerance and worsening of depression are other disadvantages of these agents.

Psychotic symptoms including paranoid thinking and mild thought disorder can be relieved by low-dose, high-potency antipsychotic agents (*e.g.*, trifluoperazine). The risk of tardive dyskinesia necessitates the judicious use of neuroleptics, which should be discontinued when symptoms are brought under control.

TABLE 3

FACTORS ASSOCIATED WITH POOR PROGNOSIS IN BORDERLINE PERSONALITY DISORDER

Comorbid major depression

History of parental brutality and incest (especially father-daughter)

Alcohol abuse

Presence of all nine *Diagnostic and Statistical Manual of Mental Disorders* criteria

Persistent impulsivity or hostility

Adapted from: Stone MH: Borderline personality disorder: Course of illness. In: Clarkin JF, et al (eds.): *Borderline Personality Disorder: Clinical and Empirical Perspectives.* The Guilford Press, New York, 1992, p. 67-86.

HOSPITALIZATION: THE SHORTER THE BETTER

Because patients with BPD often regress while hospitalized, hospitalization should be kept as short as possible.[25] Hospitalizations often occur when the patient's behavior represents a clear danger to health or life or when the patient is in a psychotic state. Hospitalization often leads to intense opinions and emotional responses among staff with responsibility for dissension among the staff, often attributed to the patient, who is then said to have "split" the staff. A well informed team with open lines of communication helps to prevent this phenomenon and is essential for successful inpatient treatment of these patients.

WHAT'S THE PROGNOSIS?

Patients with BPD usually present for the first time in their late teens or early 20s, show impaired function for five to 10 years and then improve. In long-term studies, (focused on hospitalized patients), two-thirds are doing "fair" to "well" 10 to 25 years after initial presentation.[26] Some patients take a downturn in their 40s when a sustaining relationship ends. Factors associated with poor prognosis, including suicide, are listed in Table 3.

CONCLUSION

BPD is a challenging condition both to understand and treat. Patients often make us feel angry and helpless, but awareness of etiologic factors and effective therapies not only help patients but help us feel better too. DX

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