Borderline Personality Disorder

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Introduction

Borderline personality disorder (BPD) is a highly prevalent, chronic, and debilitating disorder characterized by instability in one's sense of self, others, and mood. This instability is expressed as emotional lability, impulsivity, interpersonal dysfunction, angry outbursts, suicidality, and non-suicidal self-injury. Historically, BPD has been thought to be difficult to treat. Those with BPD tend to be high service utilizers, often in a chaotic manner. BPD is frequently comorbid with a number of other psychological disorders, particularly mood, anxiety, PTSD, and substance use disorders. When BPD is comorbid with other disorders, it has negative effects on the clinical course and outcome of those conditions. Regardless of comorbidity, BPD is related to a host of other negative and costly outcomes, including higher rates of physical and mental disability, and significant long-term functional impairment across multiple domains. Given the severity of the symptoms, the high prevalence rates, complex comorbidity, and negative effects of BPD in general and on other disorders, BPD is a major public health concern.

Epidemiology

Recent epidemiological studies suggest that BPD, with prevalence rates between 1–6% in the general population, is more common than schizophrenia, bipolar disorder, and autism combined. Clinical studies have found that 15–20% of outpatients and up to 40% of inpatients are diagnosed with BPD. BPD is often thought to occur more frequently in women than in men. Some studies have found that women account for 75% of the cases of BPD presented to outpatient departments. A number of explanations have been proposed to explain this disparity. Some authors have suggested that gender differences in prevalence rates may be due to gender bias while others have suggested that this discrepancy results from differences in symptom presentation. Women present with dramatic symptoms such as self-injury, while men present with more impulsive and substance-related symptoms.

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Other authors have suggested that women are more likely to seek treatment for symptoms related to BPD, whereas men with BPD are more likely to be in substance abuse or mandated treatment programs. However, recent epidemiological studies have found little or no differences in the prevalence of BPD between men and women.

Comorbidity with Other Psychological Disorders

BPD is frequently comorbid with a number of other psychiatric and psychological disorders such as depression, bipolar II, anxiety disorders, eating disorders, substance abuse disorders (SUD), and posttraumatic stress disorder (PTSD). This pattern of comorbidity is often referred to as *complex comorbidity* because of the number of comorbid diagnoses and the pattern that includes both internalizing and externalizing disorders. This comorbidity is especially meaningful in that the presence of BPD negatively affects the course and treatment efficacy for these disorders. Although the negative relationship between BPD and these disorders can be reciprocal, particularly for SUD and PTSD, the relationship tends to be unidirectional with regard to depression, bipolar II, and anxiety disorders. That is, the presence of BPD negatively affects the course and outcome for these disorders *but* several independent longitudinal studies comprising of thousands of patients suggest these disorders tend to have little effect on the course and outcome of BPD. For example, bipolar patients with comorbid BPD are more likely to be unemployed, use more medications, have increased rates of alcohol and substance use disorders, show poorer treatment response, and have significantly worse interepisode functioning. However, in these studies, a comorbid bipolar disorder did not affect the course or outcome for BPD patients. Likewise, a number of large-scale studies have now found that improvements in BPD were often followed by improvements in major depressive disorder but that improvements in major depressive disorder are generally not followed by improvements in BPD.

Clinical Presentation

BPD is a complex and heterogeneous clinical problem characterized by instability in self-image, mood, and interpersonal relationships. This instability manifests itself as impairments in identify, self-direction, empathy, and intimacy. DSM-IV and DSM-V note nine possible criteria for BPD. These include frantic efforts to avoid abandonment, unstable intense relationships, marked persistent identity disturbance, impulsivity, recurrent suicidal threats, gestures, and behaviors, affective instability, chronic feelings of emptiness, intense anger, and transient, stress-related paranoid ideation or dissociation. In order to be diagnosed with BPD, one has to meet any five of the nine criteria. This polythetic approach results in 256 different ways to meet criteria for BPD. Such heterogeneity is characteristic on many DSM disorders. For instance, there are also 256 different ways to meet criteria for major depressive disorder and 636,120 ways to have posttraumatic stress disorder. Nonetheless, BPD is heterogeneous. For instance, one study found 136 different combinations in a sample of 252 patients. The maximum number with the same combination was eight.

Suicidality

The most serious symptoms of BPD are the high rates of non-suicidal self-injury and suicidality. More than 84% of patients with BPD report some history of suicidal behavior, averaging 3.4 lifetime attempts. The rate of completed suicide among individuals with BPD is also very high. A recent meta-analysis found that 8% of over 1,100 patients completed suicide. This rate is not only much higher than the general population but also higher than other psychiatric disorders. For example, other meta-analyses found a suicide rate of 2.3% among over 1,500 patients with anorexia nervosa and 1.3% for unmedicated bipolar disorder. Predictors of suicidality include history of parasuicidality, hospitalizations, younger age, hostility, and impulsivity.

Non-Suicidal Self-Injury (NSSI)

Perhaps the most perplexing symptom of BPD is non-suicidality self-injury. Studies show that 70–75% of those with BPD have engaged in self-injurious behaviors, the most frequent behaviors tending to be cutting, burning, and overdosing. The reasons reported for engaging in NSSI are varied. Some have suggested that those with BPD are less receptive to pain. The evidence is mixed on this, as other studies have found that those with BPD tend to be sensitive to pain, particularly chronic pain syndromes. Other reasons reported for NSSI include combating feelings of dissociation, self-punishment, asserting control over one's behavior, distracting oneself from psychological pain with physical pain, releasing pent-up feelings of anger, guilt, shame, and stress, and to show others how bad they are feeling. Studies indicate that about a third of those with BPD who engage in NSSI begin prior to age 13, a third begin during adolescence, and a third begin in young adulthood. It is rare for those with BPD to begin cutting after their thirties, though it can occur. It is important to note that NSSI increases the risk for suicide attempts and death even in the absence of suicidal ideation. In fact, many patients with BPD accidently kill themselves while engaging in NSSI.

Assessment, Diagnosis, and Misdiagnosis

Despite the consequences of BPD, evidence suggests that clinicians often fail to recognize and diagnose personality disorders in ordinary clinical practice. One study found that 74% of BPD patients had previously been misdiagnosed despite an average of 10 years since their first psychiatric encounters. The most common false-positive diagnoses were bipolar disorder, depression, and anxiety disorders. Another large-scale outpatient study found that clinicians in routine practice diagnosed BPD in only 0.4% of almost 500 patients seen, compared to 14.4% prevalence derived when using structured interview with those very same patients. Importantly, when clinicians were provided with the findings from the structured interviews, the likelihood of the BPD diagnosis increased from 0.4 to 9.5%. Clearly the information from the structured interviews had clinical utility because the information from the structured interviews was used two-thirds of the time.

Clinicians who do not use structured or formal assessments of BPD are very likely to miss many cases of BPD, which can result in incomplete treatment. Therefore, it is recommended that clinicians formally assess for BPD as part of routine practice. It is particularly important to do so when a patient meets criteria for a disorder commonly comorbid with BPD (major depression, bipolar disorder, an anxiety disorder, posttraumatic stress disorder, or a substance use disorder). A comorbid BPD diagnosis will likely affect the course and outcome if not addressed. Likewise, complex comorbidity and/or a history of being diagnosed with various psychological disorders would also suggest to clinicians that they should formally assess for BPD. Although common comorbidities (e.g. major depression) may require simultaneous treatment with BPD, it is important not to assume that treatment of these conditions will result in the remission of BPD and privilege those treatments to the neglect of treating BPD. The evidence strongly suggests the contrary.

Treatment

BPD has historically been thought to be difficult to treat because patients frequently do not adhere to treatment recommendations, use services chaotically, and repeatedly drop out of treatment. Many clinicians are intimidated by the prospect of treating BPD patients and are often pessimistic about the outcome of treatment. Psychotherapists treating patients with BPD have displayed high levels of burnout and have been known to be prone to enactments and even engagement in iatrogenic behaviors. However, controlled trials strongly suggest that, contrary to popular belief, BPD is a treatable disorder.

Psychotherapy

There are now several treatments – deriving from both the cognitive-behavioral and psychodynamic traditions – that have shown efficacy in randomized controlled trials and are now available to clinicians and their patients. Although these treatments are often derived from either a cognitive-behavioral or psychodynamic tradition, they all tend to be either explicitly or implicitly integrative. In addition, there is a short-term psychoeducational, skills-based group called STEPPS, which has been found effective as an adjunct with other psychological treatments, and the American Psychiatric Association practice guidelines referred to General Psychiatric Management in conjunction with psychodynamic psychotherapy designed specifically for BPD has been shown to be efficacious. Thus, practitioners and patients have a range of options across a number of orientations available to them. Although DBT has been tested in more randomized controlled trials than the other treatments, findings from both direct comparisons and meta-analytic studies are clear that there is no advantage provided by DBT compared with these other approaches. Thus, there are a number of equally good treatments available to patients with BPD and there is no credible or reliable evidence that any one treatment is significantly better than any other.

Treatment Length

Because BPD is a chronic disorder that has developed over many years, it will most likely require a longer-term treatment that meets at least weekly. To date, all efficacious treatments

for BPD are a multiyear process (although most have only examined efficacy after one year of treatment). These treatments tend to be very intense and for two to five hours a week.

Expected Outcomes

Given the heterogeneity of BPD, having different treatment options is important because it is unlikely that any one treatment will be useful for all patients. Findings from randomized controlled trials (RCTs) suggest that about 50–60% of patients make symptomatic improvements within a year of treatment. Many of these individuals show changes within four to six months of treatment. Despite positive findings from RCTs, almost half the patients in treatment are not responding, regardless of treatment. Additionally, although many patients have shown symptomatic improvement and even diagnostic remission, they still experienced significant social and functional impairments. Thus, a significant portion of individuals receiving an efficacious treatment are not improving, and these individuals might be better served in different treatments.

Therapist Training

Although many of the existing empirically supported psychotherapies share many techniques with standard cognitive-behavioral therapy (CBT) and psychodynamic (PDT) treatments as they are commonly practiced in the community, it is important to note that there is little evidence that unmodified CBT or PDT (or humanistic) treatments are of benefit for those with BPD. The one RCT comparing standard CBT with treatment as usual found no reliable differences favoring CBT. The empirically supported treatments such as DBT, MBT, TFP among others have all been significantly modified from standard CBT and PDT approaches. Examples of modifications include provision of supervision or intervision, the explication of a coherent model of the problem and treatment, an increased attention to explicit frame issues, as well as a clear focus and priorities, vigilance for indications of colluding with the patient, acting out or iatrogenic behaviors on the therapist's part, and integration with other services among other aspects. These modifications are important and therefore it is recommended that clinicians who treat individuals with BPD have training in one or more of the empirically supported treatments and employ evidence-based principles deriving from these treatments and should not be using unmodified CBT and PDT.

Medications

Medications appear useful as adjunctive in the treatment of BPD but are generally not thought to be sufficient by themselves. No one specific medication has been shown to be efficacious in the treatment of BPD, which has led to a medication approach of targeting specific symptom domains rather than the disorder as a whole. The symptom domains of affect/mood, cognitive-perceptual processes, and impulsivity are frequent targets. However, this approach has become problematic, as the algorithms become quickly outdated, and the approach has led to increased rates of medication use and complicated polypharmacology issues. Such polypharmacotherapy has been associated with a number of untoward effects, including paradoxical side effects, adverse events, iatrogenic symptoms, and negative health

outcomes such as obesity and diabetes (being on three or more psychotropic medications is a greater risk factor for obesity than a family history of obesity or a sedentary lifestyle). Additionally, prescribed medications are often used in drug overdoses. There is some evidence for the superiority of monopharmacotherapy with BPD patients and for selecting medications based on tolerability and safety rather than symptom picture. Additionally, some RCTs have convincingly shown decreases in medication use related to psychotherapy efficacy.

Community Recommendations

BPD is a heterogeneous disorder. Only about 50% of patients respond to any of these treatments, and treatment responses, while clinically significant, are nonetheless incomplete. Hence, it is recommended that communities have several of the evidence-based treatments available to patients and that therapists consider obtaining expertise in more than one evidence-based therapy. Given the heterogeneity seen in BPD, it might be useful if the approaches available included both CBT- and PDT-based treatments.

See Also

Antisocial Personality Disorder
Histrionic Personality Disorder
Personality and Suicide

Further Reading

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