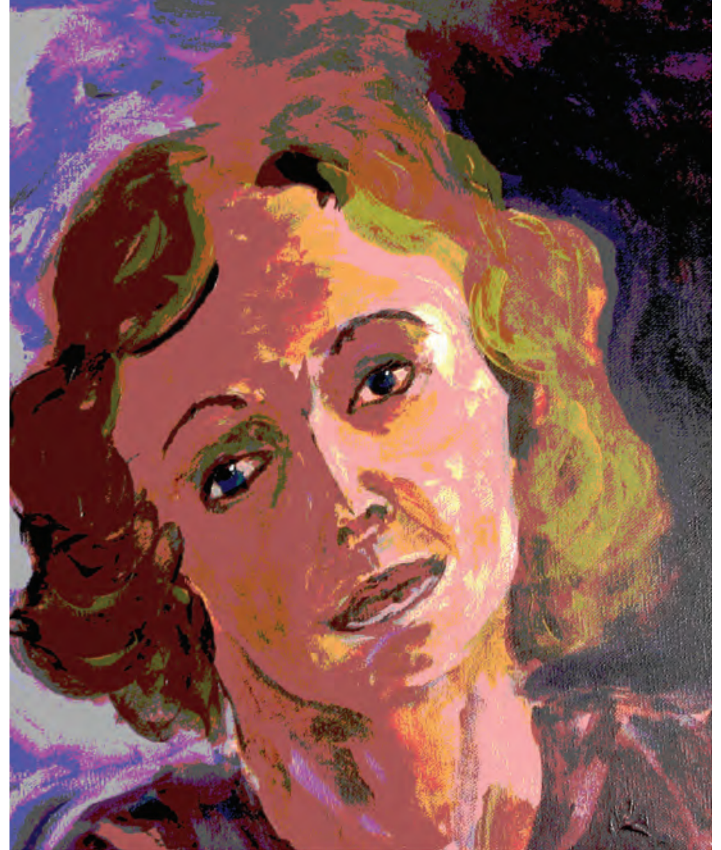
Borderline personality disorder
The difficult patient



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GPs are often the first point of contact for patients with borderline personality disorder, and this encounter can be critical in engaging these patients with health services that can provide support and treatment.

General practitioners play an important role in the early recognition of patients with borderline personality disorder and then continue in a supportive role in the ongoing management of these patients. Early recognition allows effective resolution of symptoms before the development of complications, such as serious self-harm, suicide, drug abuse and relationship breakdown.

What is borderline personality disorder?

Borderline personality disorder is a mental disorder and one of the personality disorders described in the *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition (*DSM*-5).[1] It has captured the attention of clinicians and researchers more than any other personality disorder. It is a serious, debilitating condition that can end in suicide or persistent disability in terms of symptoms and functioning.

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People affected by borderline personality disorder often experience distressing emotional states, difficulty relating to other people and self-harming behaviour. The primary disturbance in patients with borderline personality disorder is the lack of a cohesive sense of self, characterised by a disconnectedness of the internal psychological processes of the individual. This is a reflection of the lack of co-ordination between areas of brain function that usually operate together.

Patients with borderline personality disorder are largely identified by dysregulation in affect (experience of feeling or emotion) and impulse. Traits that are most descriptive of borderline personality disorder are:

- negative emotionality – emotional lability, anxiousness, separation insecurity and depressivity
- disinhibition – impulsivity and risk-taking
- antagonism – hostility.

DSM-5 emphasises the presence of dysfunction in self and interpersonal functioning (Box).[1]

Between 2 and 5% of the population are affected by borderline personality disorder at some stage in their lives. The symptoms usually appear during mid- to late-teens or early adulthood. Patients will often tell their GP, 'I have been depressed all my life'. Women are more likely to be diagnosed with borderline personality disorder than men.

What are the symptoms?

Patients with borderline personality disorder have difficulty relating to other people and the world around them. They lack the ability to put themselves in other's shoes and see things from other's perspectives. They often lack empathy for others and externalise responsibility – that is, they blame others and the outside world for problems in their own lives – expressing

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DIAGNOSTIC CRITERIA FOR BORDERLINE PERSONALITY DISORDER[1]

A. A disorder of personality is manifest by:
- impairments in self-functioning (identity or self-direction) AND
- impairments in interpersonal functioning (involving empathy or intimacy)

B. Pathological personality traits are described by:
i. emotional lability, anxiousness, separation insecurity, depressivity
ii. disinhibition (impulsivity, risk-taking)
iii. antagonism (hostility, anger)

inappropriate anger towards those they consider to be responsible for how they feel. Two domains in normal adaptive functioning seem to be disordered in patients with borderline personality disorder: self-image and self-regulatory capacity. Individuals with borderline personality disorder are vulnerable to anxiety and instability in their perception of self in relationships with others. They show more 'malevolent' representations of their caregivers.

Patients with borderline personality disorder exhibit deep feelings of insecurity and have difficulty coping with their fear of abandonment and loss. They can feel quite depressed and empty when alone, as if needing the presence of another to validate their existence, a symptom of the damaged and fragile sense of self. They continually seek reassurance, even for small things.

Persistent impulsiveness is manifested by patients abusing alcohol and other drugs, spending excessively, gambling, stealing, driving recklessly, having unsafe sex and repeatedly causing self-harm – cutting, burning, overdosing on prescription or street drugs, binge-eating or starving, repeatedly putting oneself in dangerous situations or attempting suicide.

Confused and contradictory feelings result in changing emotions and attitudes to others as well as towards aspects of life such as goals, career, living arrangements or sexual orientation. A friend one week can be an enemy the next. Such changes in attitude to another person usually occur in relation to a disappointment, often involving a sense of rejection in an interpersonal context. Individuals with borderline personality disorder tend to 'burn their bridges', leaving behind a trail of interpersonal destruction and they lack the ability to repair relationships and situations. They can cause dissent among staff on a hospital ward by idealising one staff member and denigrating another such that each person has an entirely different picture of the patient. Recognition of this 'splitting' can prevent resulting disagreement between staff. This situation can also occur within the family, in the workplace, at school or within a sporting team.

Emotional dysregulation is a hallmark of people with borderline personality disorder, which can mean they are erroneously diagnosed with bipolar disorder. Many people with borderline personality disorder also have other mental illnesses such as major depression, chronic angry dysthymia, substance use disorders, anxiety disorders, panic attacks, eating disorders and obsessive behaviours. They may also experience brief psychotic symptoms, dissociative symptoms and auditory hallucinations.

Presentation of affected patients

As a result of comorbidity, patients with borderline personality disorder present with a variety of symptoms. Common presentations include visits to emergency departments with self-harm, or seeing their GPs with suicidality, low mood or treatment-resistant depression.

Causes of borderline personality disorder

Borderline personality disorder is often attributed to a biologically based disorder of emotional regulation associated with an invalidating environment.[2] In other words, there is a genetic component and an environmental component.[3,4] There is often a history of physical, sexual or emotional abuse or neglect as a child. This leads to problems with trust, insecurity (especially regarding emotional attachment to significant others), low self-esteem, lack of any consistent sense of identity and failure of mentalisation (the ability to put oneself in another's shoes).

Investigations

A physical examination of a patient with borderline personality disorder should look for evidence of self-harm. Investigations for any comorbid conditions such as anorexia nervosa or other causes of chronic low mood should be conducted.

Treatment

Referral of a patient with borderline personality disorder to a specialist mental health service is advised for those with a severe and enduring disorder or for diagnostic clarification because treatment requires expertise and can be protracted. Shared care between the specialist (psychiatrist or psychologist), GP and community mental health teams 'spreads the load'. Supervision of the therapist by another experienced therapist is useful for support.[5]

Just as borderline personality disorder results from a lack of a secure containing relationship, so it can be treated with a secure containing relationship. This can occur naturally, for example by virtue of a good marriage or close long-term friendship, or with a good psychotherapeutic relationship. An integrated approach to psychotherapy is advocated. The first aim is to heal and foster a positive sense of self. Secondly, it is to integrate

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unconscious traumatic memory systems that repeatedly intrude into healthy mental function.

The mainstay of therapy is an empathic and validating stance. During therapy the person learns:

- new and effective ways of relating to other people
- how to recognise their emotions and control them
- to recognise a new and positive sense of self
- eventually how to integrate their experience of trauma into a narrative where it can be acknowledged, dealt with and no longer affect relationships in the present.

Successful development of reflective function or the ability to correctly infer others' mental states and intentions protects against the difficulties experienced by patients with borderline personality disorder. This process can take at least a year or more.

Several therapies have been found to help.

- Dialectical behaviour therapy addresses maladaptive and negative thought processes[2]
- Mentalisation-based therapy[6] aims to help patients to be able to put themselves in other's shoes
- Schema-focused therapy integrates elements of cognitive therapy, behaviour therapy and object relations[7]
- Transference-focused therapy includes the conversational model of therapy, which is a maturational model with the aim of healing the damaged self and dealing with prior trauma.[8]

Common psychotherapeutic techniques found to be effective include a clear treatment framework, a focus on the therapeutic relationship, attention to affect, validation of emotions (empathy), an active therapist, amplification, linking and elaboration.[9]

Medications alone do not alter the course of borderline personality disorder but can be used to treat some symptoms. The presence of a comorbid major depressive disorder or anxiety disorder is an indication for the use of an antidepressant. Mood stabilisers and antipsychotics help with mood swings and angry outbursts. The use of benzodiazepines is discouraged because of the risk of dependence, and the prescription of any psychotropic agent should be accompanied by vigilance regarding self-harm and suicidality.

Countertransference

Negative feelings towards the patient are often experienced when they externalise their anger and rage and blame the therapist for their situation and emotional state. This is a common occurrence in emergwency departments when the patient's anger is directed towards those clinicians who are trying to treat them. Sometimes there is a tendency to diagnose the patients you do not like as 'borderline'. An understanding of the psychopathology combined with a peer support group or supervisor will aid in helping the clinician to respond empathically rather than angrily.

Prognosis of affected patients

Although borderline personality disorder is a debilitating and chronic condition with a high mortality rate of up to 10%, it is eminently treatable. Even without professional therapy patients have a better prognosis than those with bipolar affective disorder, which can be equally debilitating and life-long. Borderline personality disorder does tend to ameliorate in the fifth decade, improving across a wide range of domains (e.g. social functioning, aggression, affect), especially if the patient has formed at least one long-term relationship. Therapy for even one year can lead to significant resolution of symptoms.[10]

Conclusion

When someone deliberately hurts themselves as a way of coping, others can find it difficult to understand. Unfortunately, many people will at some stage come face to face with the prejudice and discrimination that result from this. This can be extremely alienating. It is vital to remember that borderline personality disorder is a genuine condition and that help is available. The good news is that with treatment and understanding, people with borderline personality disorder can lead fulfilling lives. MT

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COMPETING INTERESTS: Associate Professor Stevenson is involved with teaching and supervising the Conversational Model of Therapy to Masters students of The University of Sydney.

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