eMentalHealth.ca

Borderline Personality Disorder (BPD): Information for Primary Care

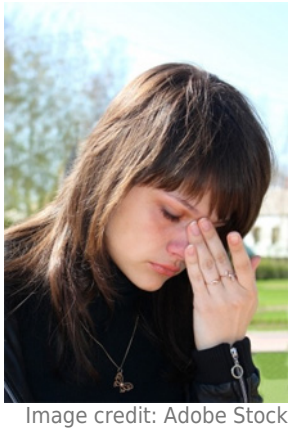

Image credit: Adobe Stock

Summary: Human beings are social creatures, and as such, our strongest need is attachments and connections with others. Individuals with borderline personality disorder appear to have unmet attachment needs, which can arise for a variety of reasons, such as past trauma/neglect or simply due to having higher needs than their environment was able to provide.

People with borderline personality disorder struggle with problems with moods and behaviours, and typically have problems functioning at school, work or home. They may have chronic thoughts of suicide, and generally have increased contact with family physicians for physical as well as mental health complaints.

To meet the patient's underlying need for connection, family physicians can focus on developing a therapeutic alliance, conveying empathy, validation and acceptance, and providing practical support and strategies. Key management strategies include referral to appropriate specialized services such as Dialectical behavior therapy or other therapies. Medications are not helpful for borderline personality disorder per se, but may be helpful if there are other comorbid diagnoses such as mood or anxiety conditions.

Epidemiology

Prevalence (Grant, 2008)

- 2-6% of the general population
- 6% of patients in primary care
- 10% of patients in an outpatient mental health clinic
- 20% of patients on an inpatient mental health ward

Age of onset: Most common in early adulthood.
Gender: Males < Females (50-80% of patients are female)

Presentation

Suspect BPD if your patient...

- Has been struggling with significant, longstanding relationship and mood problems

- Has had a history of various treatments including counseling/therapy or medications, without success
- Reports feeling lonely, rejected or abandoned in their relationships, without any longstanding secure relationships
- You experience strong feelings (i.e. counter-transference) in your interactions with the patient which may range from:
    - Feeling you need to take care of the patient (when the patient presents in a vulnerable, needy state),
    - Feeling upset and defensive (when the patient presents angry, upset and disappointed that you have not been able to meet the patient's needs)
    - Dreading that you are about to see this patient (as these patients can have high needs that can be challenging to meet)

Symptoms

Core features include a chronic history of...

- A pattern of unstable and intense interpersonal relationships
    - Patients with BPD have extremely high relationship needs that can be challenging for others to meet
    - In the beginning of a new relationship, things may go well
    - Over time however, the patient’s high needs (for emotional reassurance or to be physically present with others) may be more than the other can provide
    - As a result, patients report themes of being abandoned, rejected or disappointed by others in relationships
    - Fears about rejection and abandonment can be a self-fulfilling prophecy
    - Patients may attempt to cope with frantic efforts to avoid real or imagined abandonment
- Problems with self-image such as lack of self-identity or low self-esteem
    - When not physically with other people, patients may report feeling empty or alone; they may have difficulties feeling secure in their relationship with another person if the other person is not physically present.
- Problems with emotional regulation, including impulsivity
    - When all is well, may be incredibly euphoric, passionate, spontaneous and fun to be with
    - Conversely, when under stress, may have extreme mood swings, with sadness, anxiety, or irritability/anger
    - Due to problems with coping, they may use strategies such as self-injurious behaviours

Screening Tools

History

Process

- As with all patient encounters, building a strong therapeutic alliance is universally helpful
- When seeing a patient with BPD, be mindful that they are sensitive to feeling rejected, minimized or invalidated
- Thus, pay extra attention to eliciting feelings, and validating and accepting how the patient is feeling
- For example, even if you disagree with the patient's behaviours (e.g. self-cutting), you can still agree with the patient's feelings (e.g. that they felt sad and frustrated when they discovered their friend cancelled their plans at the last minute)

Useful questions based on DSM-5 criteria to explore for borderline personality disorder

- Attachment / Relationship
    - Who are the closest people in your life? E.g. Parents? Other family? Friends? Pets?

    - When you are upset, are you able to turn to others?
        - If so, how are they supportive?
        - If not, what makes it hard to turn to others?
    - Do you feel that they love you no matter what? (e.g. that they love you even if you are struggling, or that they love you even if you do poorly at school, sports, etc.)
    - Or do you feel that their love is conditional? (e.g. needing to be good enough, pretty enough, smart enough, etc.)
    - Do you worry a lot about being abandoned or rejected?
    - Do you find that things tend to vary between the extremes of being very good or very bad?

Self-regulation

- When you are under stress, do you start feeling paranoid and thinking that everyone is against you? Or spacing out?
- Do you have troubles controlling your anger? (e.g. losing your temper? Getting into fights?)
- Do you get mood swings?
- Do you have problems being impulsive? E.g. spending excessive amounts of money? Having sex? Using alcohol or drugs? Reckless driving? Binge eating?

Self-concept, self-acceptance, self-compassion

- Do you feel empty inside?
- Do you accept yourself? Or do you tend to think you're a bad person?
- Self-injury
    - When you get stressed, do you ever hurt yourself to cope?

Other areas to cover in the interview

- Rule out other psychiatric disorders or comorbid conditions
    - Depressive symptoms: Any problems with mood?
    - Anxiety: Any problems with anxiety?
    - ADHD: Any problems paying attention in school?
    - PTSD: Have there been significant past stresses, such as physical assault, abuse, neglect, bullying, family psychiatric / medical illnesses, etc.?
    - Bipolar disorder: Are there distinct high periods with grandiosity? Are there periods of circadium rhythm disturbance, i.e. periods with decreased need for sleep yet with high energy?
    - Psychotic symptoms: Seeing any things that others don't see? Hearing any things that others don't hear? Any worries that others are out to harm you?
- Assess for degree of impairment
    - Review occupation/education, interpersonal relationships, finances
- Review risky behaviours such as
    - Substance use, safe sex practices, gambling
- Safety
    - Assess for suicidality
    - Ask about self harm
- Medical review of symptoms (ROS)
    - Patients may have various somatic complaints

Diagnosis by DSM-5

BPD is manifested by a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Frantic efforts to avoid real or imagined abandonment. Note: Do not include suicidal or self-mutilating

behavior covered in (5).
2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation. This is called "splitting."
3. Identity disturbance: markedly and persistently unstable self-image or sense of self.
4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). Note: Do not include suicidal or self-mutilating behavior covered in (5).
5. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior.
6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).
7. Chronic feelings of emptiness.
8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
9. Transient, stress-related paranoid ideation or severe dissociative symptoms.

- Note that although the DSM-IV has been upgraded to DSM-5, there are no changes with symptom criteria between the two versions.

Differential Diagnosis

Because individuals with BPD can experience problems with mood (such as depression), anxiety, and mood swings, their symptoms can resemble other DSM conditions.
What distinguishes BPD from other conditions however is the core sense of

- Feeling insecure in one's attachments (as manifested by fears of abandonment, rejection)
- Chronic feelings of emptiness
- Severe problems with affect and self-regulation problems (i.e. problems managing feelings, which means they react to stresses with extreme feelings such as sudden anger, sadness, anxiety)

Conditions to consider in the DDx include:

- Anxiety
  - Individuals with anxiety disorders feel anxious and nervous, perceiving that 'the world is a dangerous place' and/or 'I am not competent'
  - Similarly, individuals with BPD may similarly view the world in a similar fashion, due to their underlying issue with feeling insecure (i.e. disconnected from others) in their attachments
- Depression
  - Individuals with depression are often feeling depressed due to interpersonal stressors such as interpersonal conflict, or rejection
  - This overlaps with BPD, because individuals with BPD similarly can feel lonely and empty (with sadness), due to stresses in their attachments
- Bipolar disorder
  - Individuals with bipolar disorder have mood swings
  - Similarly, individuals with BPD can have mood swings, however mood swings in BPD are rapid and usually clearly in response too a clear stress (e.g. perceived rejection or abandonment by others)
  - Mood disorders in classic bipolar I or II are distinguished by not just mood swings, but changes in circadian rhythm disturbance (e.g. increased energy with decreased need for sleep)
- ADHD
  - People with undiagnosed ADHD can experience significant impulsivity and mood swings due to the impulsivity of ADHD
  - Successful treatment of impulsivity and attention problems can thus improve their function significantly, including stability of their relationships
- Psychotic disorders
  - When under significant stress, individuals with BPD can have visual hallucinations. That experience with other people (as well as the world) as being a scary place, and having hallucinations can be one

manifestation of this
    - Post-traumatic stress disorder (PTSD)
    - Many individuals with BPD have experienced trauma
    - PTSD is characterized by previous traumatic event and re-experiencing of the trauma (e.g. flashbacks)

Comorbidities

Because having secure attachments are such an integral resiliency and protective factor, not feeling secure in their attachments can thus predispose an individual with BPD to have all manner of mental health issues including:

- Mood disorders such as dysthymic disorder, major depression, and bipolar disorder
- Anxiety disorders such as generalized anxiety disorder, separation anxiety disorder
- PTSD, which can occur because individuals with BPD are at a higher risk of having unhealthy relationships and experiencing abuse or trauma from others

Assessing Suicidality

Explore and manage suicidal ideation or parasuicidal behaviours

- Patients with borderline personality disorder have the same need to feel connected with others that everyone has
- Unfortunately, patients with borderline personality disorder have problems tolerating separation from others, and as a result, any separations (e.g. physical separation, emotional separations such as conflict, perceived rejection, etc.) can be stressful and overwhelming, to the point where the patient may have passive or even active suicidal ideation

Thoughts of suicide arise when a person’s stresses become overwhelming, or when the reasons to die greatly outweighs the reasons to live

- Clinician:
    - “I am so sorry that you’ve had more thoughts of suicide lately. Tell me more about those thoughts?”
    - Intent: "How strong are your thoughts to end your life?"
    - Means: "How are you thinking about ending your life?" "Do you have access to that?"

Explore possible stresses or triggers

- Thoughts of suicide can occur when the patient is feeling overwhelmed by stressors, typically relational or interpersonal stressors
- Thus, one way to support the patient is to help them identify their stressors, and help them find alternate ways to cope
- Example:
    - Clinician: “Everyone has stresses, such as school, work, relationships (such as family or friends). What are your top stresses?”
    - Connection before direction
        - "Connect": Validate how the patient feels, then
        - "Direct": Ask for permission and offer advice or problem-solve with the patient
        - E.g. Clinician: “I’m so sorry to hear about the situation with your boss. That sounds like such a horribly stressful situation to be in. I can definitely see how you'd feel upset about that.”
        - Do not tell the patient what to do before you have empathized or validated, because then the patient will feel invalidated.

Assess any protective factors

- Validate
    - Clinician: “I am so sorry that things are stressful to the point where you are feeling this way.

    - Clinician: "The fact that you are alive tells me that the part of you that wants to live is stronger..."
- Explore reasons for living
    - Clinician: "What's kept you alive?" "Who has kept you live?"
        - Religious beliefs, e.g. “Is faith or religion a source of strength for you?”
        - Hope (future-thinking), e.g. “What gives you hope?”
- Assess any positive coping strategies
    - Clinician: "Anyone you can talk to about what’s been going on?”
    - Clinician: "What have you found helpful to cope?"
- Express your willingness to support the patient
    - Clinician: “Sounds like you have been under a lot of stress lately. How can I support you?"
- After validation and empathy, then ask if they want advice, reassurance or problem-solving.
    - Support the patient with problem-solving or giving advice, but only if the patient has asked you and/or is giving you permission
    - Explore coping strategies such as
        - Problem-solving the individual stresses
        - People to talk to
        - Activities to turn to
        - Mindfulness meditation
- Support the patient with any thoughts of self-harm / suicide
    - Although self-harm is distinctly different from suicidal ideation, they are both similar in that they both result from being overwhelmed by stresses
    - Self-harm is generally a coping strategy to help the patient feel better
    - Suicidal ideation is generally a strategy when the patient feels that their stresses are overwhelming, with not enough protective factors to keep them living
    - Options include
        - Identify the patient’s stresses
            - Clinician: “Everyone has stresses, such as school, work, relationships (such as family or friends). What are your top stresses?”
            - Ensure that you validate how the patient feels **before** trying to give advice or problem-solve
            - Clinician: “I’m so sorry to hear about the situation with your boss. That sounds like such a horribly stressful situation to be in. It’d be normal for anyone to feel upset about that.”
            - Support the patient with problem-solving or giving advice, but only if the patient has asked you and/or is giving you permission
                - Clinician: “Sounds like work is a big stress. Is there anything I can do to help with that stress?”
    - Explore coping strategies such as
        - Clinician: "What if we could find some ways for you to deal with this stress?" "Any preferences on what you'd like?"
        - Distraction activities such as going for a walk, taking a bath, riding a bike, going out to chat with a friend
        - Mindfulness meditation
    - Be aware that patients with BPD may feel rejected, which may lead them to reject them prior to being able to reject them
    - Situations may be as simple as the health care provider (e.g. such the family physician setting a limit, such as refusing to see the patient if the patient is excessively late for a visit, or declining to do something that the patient is asking for)

- Disposition depending on low, medium or high risk
    - If passive suicidal ideation: Arrange outpatient services
    - If acute suicidal ideation: Contact emergency services

Mental Status Examination (MSE)

Mood: May be normal, or down

Thought content: May have chronic suicidal ideation
Psychosis: During times of extreme stress, may have symptoms of hallucinations or delusions, so called "micro-psychotic" episodes, with theme that others are against them

Physical Exam (Px)

Look for signs of self-injury on

- Extremities such arms, legs. Note that patient may try to hide self-injury; gently ask about self-injury.
- Abdomen

Prognosis

Long-term prognosis is relatively good for most individuals with BPD

- 75% will have normal function by age 35-40
- 75% of hospitalized patients with have remission in 6 years
    - Patients in remission may still have high functional impairment

1 – 4% will complete suicide

- More attempts in 20 year olds, whereas more completions in 30 year olds
- Self-harm not correlated with suicide attempts or completions
- Protective factors – higher IQ, lack of narcissism, no parental divorce
- Poor outcome predictors – affective symptoms, family history, length of hospitalization, dysphoria, younger age at onset, parental abuse, maternal pathology

Management / Treatment

- Patients with BPD are craving attachments; thus, the most important long-term intervention is helping them build and keep long-term attachments.
    - Always be empathetic and supportive of the patient, as this meets their core attachment need of feeling cared for by others.
    - Though this is intuitive, this is even more important for individuals with BPD, as they are extremely sensitive to rejection.
    - This can be challenging given that the nature of BPD that patients experience the world as rejecting, which can lead them to be demanding and clingy.
    - Unfortunately, by being demanding and clingy, this can overwhelm family, friends and health professionals, which leads them to be rejected, and hence, their experience of others as rejecting becomes a self-fulfilling prophecy.
    - Because individuals with BPD have high needs, they are often at risk of being ignored even by health providers, who may feel countertransference and a need defensively distance themselves.
    - Example of empathy with the angry patient
        - Patient: "How dare you keep me waiting! I had to wait 15-minutes -- you don't know how frustrating it is."
        - Clinician: "Thanks for letting me know how strongly it affects you. I can agree, I can completely understand how you'd feel frustrated. After all, here you are, making all this effort to come, and I am not able to see you on time. I am really sorry. I am here now. How can I be helpful to you today?"
- Appropriate limit setting

    - Because patients with BPD experience others as not meeting their needs, they are often desperately needy.
    - Health care professionals may need to set clear boundaries, in order to avoid getting burnt out.
    - Be aware that this may be interpreted as rejection by the patient, and thus, ensure that any limit setting is also balanced by hope, and an offer to see the patient again.
    - For example, patient who is always late:
    - Clinician: “It is simply not possible to see you if you are more than 15-minutes late for your appointment, nor is it possible for me to have a telephone conversation as a substitute for an appointment in person. I really wish that I could, but I just can’t. But you can contact my secretary, who can book something with you.”
    - For example, patient who may show up intoxicated to a visit
        - Clinician: “If you arrive to an appointment intoxicated, I will not be able to see you. But I’m happy to see you when you are no longer intoxicated.”
- Meet attachment needs by being consistent and reliable
    - Offer the patient frequent visits
    - At the start of each visit, set clear goals
    - Prioritize issues, as the BPD patient may have numerous goals and priorities
    - Be careful when dealing with splitting behaviours within in the health care team
    - Do not criticize other members of the health care team, but validate the patient’s experience
- Give the diagnosis of BPD to a patient
    - Often under-diagnosed or diagnosis not told to patient, however, disclosure allows for better understanding of expectations and management
    - Clinician: “Thank you for coming and telling me how you have been feeling. I have some good news and some bad news. First, the bad news. You have told me that you struggle with fears of being rejected or abandonment, low self-esteem, and mood swings. I believe that these symptoms you have may be part of a condition known as borderline personality. The good news is that there are many ways to help.”
    - Resources include
        - People with Intense Emotions
        - Borderline Traits in Children and Youth
- Refer to counseling/psychotherapy, such as Dialectical Behaviour Therapy (DBT)
    - DBT is mainstay of treatment for BPD, however there may be limited access with long wait times
- Address physical complaints
    - Be specific and focused during discussion of physical traits
    - Openly discuss the role of psychosocial factors in the development and experience of physical ailments
- Help the patient with coping strategies
    - Patients with BPD are often overwhelmed by their stresses and may then turn to negative coping strategies (e.g. self-injurious behavior) as a way of copin
    - Fortunately, there are ways to support the patient with developing more healthy strategies such
        - Problem-solving
        - Clinician: “What are your biggest stresses these days?” “Which one would you like to work on?” “Any ideas on how to work on this issue?”
- Use resources
    - Provide patient with resources in the community
    - Get patient to list resources they have – i.e. friends, family members, community workers
    - Be as specific as possible about how and when to access them
    - i.e. call friend A when I have thoughts of self-harm, if friend A is busy I will call family member
- Mindfulness and relaxation
    - Provide specific instructions – i.e. box breathing techniques, go through all 5 senses and specifically notice how each one is affecting you
    - Refocusing energy
    - Find other activities the patient can use – i.e. write about feelings, draw or paint, sing, exercise, play

an instrument

Medications

Medications have little evidence for efficacy in BPD alone, however medications may have a role in treating co-morbid conditions or specific symptoms clusters:

1. Affective dysregulation
    - Mood lability, rejection sensitivity, inappropriate intense anger, depressive "mood crashes," or outbursts of temper
    - Treatment
        - First-line: Selective serotonin reuptake inhibitor (SSRI) or related antidepressant such as venlafaxine can be helpful for mood issues including anger
        - Second-line: Mood stabilizers such as lithium, valproate, carbamazepine
        - Third-line: Low dose neuroleptic: With disinhibited anger, or severe behavior problems, consider low-dose neuroleptics can be added to the regimen for rapid response and improvement of affective symptoms
2. Impulsive-behavioral dyscontrol
    - Symptoms include impulsive aggression, self-mutilation, or self-damaging behavior (e.g., promiscuous sex, substance abuse, reckless spending)
    - Treatment
        - SSRIs are the initial treatment of choice such as
            - Fluoxetine
            - Citalopram
3. Cognitive-perceptual difficulties
    - Symptoms include suspiciousness, referential thinking, paranoid ideation, illusions, derealization, depersonalization, or hallucination-like symptoms.
    - Treatment
        - Low-dose neuroleptics are the treatment of choice
        - May also help with other symptoms such as depressed mood, impulsivity, and anger/hostility.
        - If response is suboptimal, the dose should be increased to a range suitable for treating axis I disorders

Where to refer

Most patients with BPD will benefit from specialized, mental health treatment or therapy.
Refer to mental health professionals that can provide evidence-based treatments such as

- Cognitive behavioural therapy (CBT) for BPD , e.g. “schema focused therapy”
- Dialectical behavior therapy (DBT)
- Psychodynamic, or other therapies that are available in your area

Self-Help Books

For individuals with BPD

- The Borderline Personality Disorder Survival Guide by Alex Chapman and Kim Gratz;
- The Dialectical Behavior Therapy Skills Workbook: Practical DBT Exercises for Learning Mindfulness, Interpersonal Effectiveness, Emotion Regulation & Distress Tolerance by Matthew McKay, Jeffrey Wood and Jeffrey Brantley, 2007.
- Mindfulness for Borderline Personality Disorder: Relieve Your Suffering Using the Core Skills of Dialectical

Behaviour Therapy, by Blaise Aquirre and Gillian Galen, 2013.
- Don’t Let Your Emotions Run Your Life, Scott Spradin, Jan 2003.

For family and friends of someone with BPD

- Loving Someone With Borderline Personality Disorder: How to Keep Out-of-Control Emotions from Destroying Your Relationship, Shari Manning and Marsha Linehan, 2011.
- The Stop Walking On Eggshells: Taking Your Life Back When Someone You Care About Has Borderline Personality Disorder, by Paul Mason and Randi Kreger, 2009.

References

American Psychiatric Association.Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition.American Psychiatric Publishing, 2013.

CAMH, Suicide prevention and assessment handbook. Ed: D. Ballon and J. Waller-Vintar. 2011.

Grant BF et al. Prevalence, correlates, disability, and comorbidity
of DSM-IV borderline personality disorder: results from the wave 2 National Epidemiologic Survey on Alcohol and Related Conditions. J Clin Psychiatry 2008; 69:533-545.

More...

About this Document

Written by Dr. Erin Boyd, Family Medicine Resident, Class of 2015. Reviewed by members of the Family Medicine Program at the University of Ottawa, including Dr's Farad Motamedi; Mireille St-Jean; Eric Wooltorton (2014).

Disclaimer

Information in this pamphlet is offered ‘as is' and is meant only to provide general information that supplements, but does not replace the information from an accredited Continuing Medical Education (CME) provider.

Creative Commons License

You are free to copy and distribute this material in its entirety as long as 1) this material is not used in any way that suggests we endorse you or your use of the material, 2) this material is not used for commercial purposes (non-commercial), 3) this material is not altered in any way (no derivative works). View full license at http://creativecommons.org/licenses/by-nc-nd/2.5/ca/