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Does this patient need psychiatric referral?

Borderline personality disorder is serious, life-threatening, and fairly common, yet it goes unrecognized by most physicians.

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Borderline personality disorder (BPD) is a severe and life-threatening condition. Although it occurs relatively frequently, exacts an enormous toll in human suffering, and contributes significantly to national health care costs, this condition was not identified until quite recently. Because its nature and manifestations are only now becoming clear, BPD has remained obscure or unknown to most health-care professionals.

In the 1960s and 1970s, clinical studies of possible variants of schizophrenia revealed a sizable patient group that was difficult to classify.[1,2] These patients were very disturbed at times and yet could be quite rational and perceptive at others. They were thought by most psychiatrists at the time to be on the verge of schizophrenia (hence "borderline") or to have a disguised form of the disease ("pseudoneurotic schizophrenia").

The seminal research of Gunderson in the 1970s[1] identified objective diagnostic criteria that engendered many large-scale studies of BPD patients. These studies showed that BPD was not a variant of psychotic illness and did not progress to schizophrenia. As a result, it has been redefined as a personality disorder of unknown etiology.[3] However, as will be discussed later, recent research suggests that BPD is not so much a personality disorder as a serious illness brought about by childhood trauma.

EPIDEMIOLOGY

A 1990 epidemiologic study conducted by Swartz and colleagues found that BPD occurred in approximately 2% of a sample of the general population, 73% of them women.[4] The data also revealed that approximately 50% of respondents with BPD had used some form of outpatient mental health service in the past 6 months and 19.5% had had an inpatient hospitalization in the previous year. The authors report that BPD occurs in over 10% of psychiatric outpatients, about 20% of inpatients, and more than 60% of inpatients in clinical settings where personality disorders predominate.

CLINICAL FEATURES

The current diagnostic criteria for BPD are given in the Table,[3] although investigators continue to debate its core features.

BPD involves dramatic and severe symptomatology that pervades many aspects of functioning, including relationships, sense of self, mood, and behavior (see box, "Recognizing BPD in the Primary Care Setting"). Individuals with BPD live in almost constant psychic pain, burdened by self-hate; a great longing for intimacy yet distrust of others; intense, painful relationships characterized particularly by frantic efforts to avoid abandonment; potentially self-damaging impulsiveness; and chronic dysphoria that can quickly progress

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to severe depression and suicidal thinking and behavior. They have a pervasive sense of their badness, and their severely damaged sense of self manifests itself in great confusion about who they are, what they value, **and** what they want in life. They may attempt to relieve their anguish by inflicting physical injury on themselves.

When undergoing interpersonal stress, BPD patients easily become confused and enraged and, when this causes others to distance themselves, suffer extremes of emptiness and abandonment. Many BPD patients also have a heightened perceptivity of people's feelings and motives, which can manifest itself in a powerful manipulative influence over others, termed "projective identification."[5,6] In another manifestation of this characteristic, the patient is remarkably appealing and compelling, which is sometimes associated with role-boundary violations by therapists, including sexual intimacy.[7]

Approximately 10% of BPD patients commit suicide, usually relatively early in their illness. One major study found that 38% of women who had BPD with comorbid major depression and alcohol abuse committed suicide.[8]

Table

*D5M-IV diagnostic criteria for borderline personality disorder**

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. (Do not include suicidal or self-mutilating behavior covered in criterion 5.)
2. A pattern of unstable and intense interpersonal relationships characterized by alternating extremes of idealization and devaluation.
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 (eg, spending, sex, substance use, reckless driving, binge eating). (Do not include suicidal or self-mutilating behavior covered in criterion 5.)
5. Recurrent suicidal behavior, gestures, or threats or self-mutilating behavior.
6. Affective instability due to a marked reactivity of mood (eg, 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 (eg, frequent displays of temper, constant anger, recurrent physical fights).
9. Transient, stress-related paranoid ideation or severe dissociative symptoms.

**Criteria are numbered in order of decreasing diagnostic efficiency.*

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ETIOLOGY

Numerous etiologic theories have been advanced about BPD,[9] and specific clues are provided by two facts: the great majority of BPD patients also suffer from clinical depression, and approximately one third meet the criteria for posttraumatic stress disorder."[10] Many recent studies have also reported childhood physical and sexual abuse in the majority of BPD patients,[11-13] who tended not to recognize or report it spontaneously. However, since such abuse was not found in all cases of BPD, the search for a common etiologic factor continued.

A recent study found that throughout childhood, all BPD patients evaluated[14] had suffered chronic, severe, and pervasive psychological abuse, with or without a physical/sexual component, to the extent that the de-

Recognizing BPD in the primary care setting

When present in a cohesive pattern, various signals can alert the primary care physician to the presence of BPD and the need for immediate referral to a specialist.

Patients are often lonely young adults, usually women, who tend to present with a combination of chronic moodiness and/or depression and somatic complaints. The physical complaints frequently have an inadequate objective basis and may occasionally sound bizarre (eg, the sensation that the arms are falling off or that there is an itch inside the head). Patients may have self-inflicted injuries, bruises, or cuts that they may explain away as incurred in an accident or caused by someone else.

BPD patients may express great uncertainty about their identity, goals, and values and have an excessive need to talk about self-doubts and upsetting personal relationships. They may be angry, self-sabotaging, impulsive, confusingly appealing and charismatic, and anxiety-provoking all at the same time. There is often a history of suicidal thinking and failed mental health care.

veloping self was invalidated in the extreme. There was also evidence that three fourths of these patients had a talent for perceiving the feelings and motivations of others, which may have made them vulnerable as children to pathologic aspects of caretakers' personalities.

TREATMENT

In light of our current understanding, it now seems that these chronically disturbed individuals have a mental illness created by environmental events rather than biologic causes. Therefore, treating BPD is fundamentally different from treating a psychotic illness. Suicide prevention is a major concern, particularly early in treatment.[15] Rather than treating only disturbing symptoms and behaviors, therapy focuses on helping patients understand and deal with what has happened to them.[6,16,17] These patients can be difficult to treat, even for experienced therapists, largely because of the strong emotional responses (countertransference) they evoke.[2,5]

Medication: Although there is no specific drug therapy for BPD, pharmacotherapy is frequently necessary. The comorbid disorders that are usually seen with BPD ó mood, anxiety, phobic, posttraumatic, substance-abuse, eating, and panic disorders[4] ó provide guidelines to appropriate drugs.

Depression is so common in BPD that a trial of antidepressants is usually warranted.[2] Selective serotonin reuptake inhibitors (ie, fluoxe-

tine, sertraline, paroxetine) are usually the drugs of choice, often helping to calm patients and reduce their depression, anger, impulsivity, and vulnerability to stressful events. If drug-induced sexual dysfunction becomes a problem, bupropion can be tried.

Monoamine oxidase inhibitors can be effective but require a strict dietary regimen. Heterocyclic aniidepressants are not well tolerated, perhaps because of the sensitivity of BPD patients to side effects. Mood stabilizers (eg, lithium) are sometimes effective. Low-dose dopamine antagonists and anxiolytics can be helpful in selected cases, although I many patients have a negative response.

PROGNOSIS

Clinicians have generally considered BPD patients unreliable and often unresponsive to treatment, creating crises and suicidal emergencies. However, long-term follow-up studies have demonstrated the striking and unexpected finding that after 15 years, two thirds of the patients studied were no longer "borderline" and were functioning normally or with only minimal symptoms.[8,15]

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