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Borderline Personality Disorder: Implications in Family and Pediatric Practice

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Abstract

The diagnosis and management of Borderline Personality Disorder can be a particularly complicated problem in family and pediatric practice. This disorder, while highly prevalent, receives little attention outside the mental health specialties. The current review article examines the scope of the problem from a public health perspective, educates the reader regarding common clinical presentations of Borderline Personality Disorder and describes methods to address issues surrounding these patients.

Keywords: BPD; Cluster B personality disorder; Borderline personality disorder

Introduction

Borderline Personality Disorder (BPD) is a psychiatric condition that passes largely unnoticed in family practice. Most practitioners are attuned to the pernicious impacts of schizophrenia and depression, yet we hear little about the considerable public health consequences, the high mortality and the profound psychosocial impairment of the more than 18 million Americans diagnosed with BPD [1].

The goal of this review article is: to address borderline personality disorder from a public health perspective, to summarize and integrate the diverse literature in the field and to share clinical pearls that will enable clinicians to better diagnosis and assist personality-disordered patients and their families.

Review and Discussion

Epidemiology/Public health issues

Approximately 6% of the adult U.S. population has BPD [1]. The behaviors of these individuals significantly affect society because the core of their dysfunction involves *interpersonal* relationships. Thus, it is a "social disease" affecting far more Americans than HIV/AIDS. Moreover, the mortality rate attributed to suicide from BPD approaches 10%.

The scope of BPD outreaches the reported prevalence. Because it is a disorder characterized by rage, violent behaviors and impulsivity, the patient "*exports*" the mortality and morbidity to family, neighbors and coworkers. A recent study reported as great as 65% of the U.S. prison population suffers from BPD or other closely related, usually diagnostically indistinguishable, Cluster B Personality Disorders [2]. A similar survey in the United Kingdom reported 78% Cluster B Disorders [3]. Moreover, 60% -80% of mental health inpatients are similarly afflicted [4]. Data from the 'Collaborative Longitudinal Personality Disorders Study' has shown that treatment-seeking patients with borderline personality disorder report greater use of psychiatric medication, hospitalization, psychotherapy, day care and social care compared to patients with major depressive disorder [5]. Thus, the Public Health burden of BPD is substantial.

BPD is *diagnosed* more frequently in women than men (3:1). The "diagnosis rate" may not actually reflect the true prevalence. The American Psychiatric Association, (APA), notes that the disorder may be missed in men. Specifically, men with the same behavioral features as women, tend to be assigned the diagnosis "antisocial or narcissistic personality disorder" rather than BPD [6]. There is also epidemiological controversy over age distribution. BPD seldom is *reported* in adolescents; however, under-reporting may be due to bias rather than actual low prevalence.

Diagnosis

Diagnosis is difficult because many personality-disordered patients can maintain a façade of mental health during a casual clinical interview. They are charming, engaging individuals who can evoke a great deal of sympathy from their physicians. Yet these are the individuals who later will draw the clinician into intense conflicts. These are the patients who are medically non-compliant, do not pay their bills and sue for medical malpractice. Their relationship to the health care team often is fragile, stormy and inappropriate. Furthermore, pediatricians need to be attuned to borderline behaviors because of the association between personality-disordered parents and physical and/or emotional child abuse or neglect. Moreover, domestic violence and substance abuse are common features in BPD patients.

Diagnostic Nomenclature: *The Diagnostic and Statistical Manual of Mental Disorders*, DSM IV, the diagnostic manual of the APA, characterizes a personality disorder as:

- An *enduring pattern* of behavior leading to *significant distress* or *impairment*.
- A *rigid and unchanging* pattern that exists well outside the patient's cultural norms.

Under the multiaxial diagnostic scheme introduced with DSM III, BPD is classified as an "Axis II" disorder (Axis II has no special significance. It is simply the category the APA relegated to every condition that did not fit into Axis I). Many psychiatrists are more comfortable with broader diagnostic nomenclatures such as: "Cluster B Personality Disorder" or "Impulse Disorder". This is because BPD generally presents clinically as a **blend** of *all four* "Cluster B" personality

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disorders (Borderline, Narcissistic, Histrionic and Antisocial Personality Disorder). Some mental health experts prefer the term, "Emotional Dysregulation Disorder" or "Dyslymbia"(to reflect the dysfunctional limbic system). In clinical practice, the label doesn't matter. Rather, it is more important to recognize the specific behavioral patterns of BPD and the analogous patterns of the closely related personality disorders with which it coexists.

Practice Pearl 1: *To a high degree, BPD behaviors are predictable. Tellegen [7] describes personality traits as quasi-nomothetic or "law-like". That is, observations regarding group characteristics consistently and reliably apply across individuals within the group. This is a familiar concept for physicians yet typically incomprehensible to laymen. For example, the characteristics of a group of patients diagnosed with trisomy 21 apply across all variables. That is, regardless of ethnicity or cultural background, an individual patient demonstrates the characteristics of the group (characteristic facial features, gait and mental retardation). Thus, in nomothetic disorders, if the diagnostician understands the characteristics of the group, he/she can predict the behaviors of the individual. In personality disorders, behaviors are further predictable because these patients are fundamentally limited when it comes to their repertoire of emotional and cognitive responses. This cripples them because they come to rely on the same set of inappropriate 'tools' for every occasion.*

Diagnostic Concerns: BPD is a complex mental illness. The diagnosis may be complicated. For example, BPD has been shown to be comorbid with several Axis I conditions such as Bipolar Disorder, Posttraumatic Stress Disorder, major depression, and/or Substance Misuse [8]. Not only does BPD coexist with Axis I disorders, but also as stated earlier, BPD can present as a blend of all four "Cluster B" personality disorders. *Borderline Personality Disorder* (BPD) represents approximately 2% of the population [9]. *Histrionic Personality Disorder* (HPD) affects about 2% of the population [10]. *Antisocial Personality Disorder* (ASPD) comprises approximately 4% of the general population [10] and *Narcissistic Personality Disorder* (NPD) accounts for an estimated 1% of the population [9]. The diagnostician often sees the complete tetrad within a single patient-- perhaps one disorder showing greater penetrance than the others do. Mental health professionals commonly use several reliable semi-structured clinical interviews as a diagnostic aid [11]. Nevertheless, an attuned family practitioner can discern the characteristic behavioral patterns from an office interview. This is because *behaviors of personality disordered individuals are highly consistent and predictable*.

BPD patients live in unremitting psychic pain, burdened by self-hate; distrust of others; intense, troubled relationships; self-damaging impulsiveness; and chronic dysphoria.

A helpful acronym for remembering the nine DSM criteria for BPD is: **AM SUICIDE**

Criterion 1: Fear of **A**bandonment is a core issue with BPD patients. These patients need to feel secure in all social relationships including "doctor-patient". Thus, they act exceedingly friendly and charming to get you to like them. Real or imaginary feelings of inattention initiate "frantic efforts" to avoid the "abandonment". In the clinical setting such efforts can include: exaggeration of physical illness, seductive behaviors, allusions to suicide or overt threats of self-harm, verbal abuse, destruction of your cherished possessions, assault, accusations of sexual misconduct [12], accusations of professional negligence and/or legal retribution.

Practice Pearl 2:

A: **A**bandonment (frantic efforts to avoid real or imagined)

M: **M**ood instability (reactive interpersonal mood states)

S: **S**uicidal (or self-mutilating) behavior

U: **U**nstable and intense relationships (frequent arguments, highly emotional, characterized by alternating between extremes of idealization and devaluation)

I: **I**mpulsivity (in 2 or more potentially self-damaging areas)

C: **C**ontrol of anger (inappropriate and intense)

I: **I**dentity disturbance

D: **D**issociative, quasi-delusional and/or paranoid transient, stress-linked symptoms

E: **E**mptiness (chronic feelings of)

BPD patients appear to have hair-trigger responses to what they perceive as 'invalidation' of any kind. This is problematic for those who interact with the BP, because at times innocuous words or actions (real or referential) may be interpreted as secretly harboring malicious abandonment.

Criterion 2: BPs struggle with **M**ood shifts. They rarely recognize their dramatic shifts of mood. Nonetheless, their affective instability complicates relationships with family, coworkers or the healthcare team. Thus, the BP experience is marked by drama and chaos -- BPDs import crisis situations to their homes, their workplace *and your office*.

Criterion 3: **S**uicide and/or self mutilation formerly was considered pathognomonic for BPD. We know now, that individuals diagnosed with BPD often do not display overt self-destructive behaviors. Nonetheless, the clinician should remain sensitive to suicidal ideation and other expressions of self-injury such as: cutting or burning one's skin, substance misuse or reckless sex.

Criterion 4: Were it not for their intense **u**nstable interpersonal relationships, the behaviors of BPs might fall beneath one's diagnostic radar. In a clinical relationship, one can readily become a casualty of the BP's inability to assess realistically the limits and boundaries of interpersonal relationships. For example, the doctor may become entwined in the idealization/devaluation cycle common in BPD relationships. Initially, the patient offers inordinate praise drawing you into a closer bond. The patient then expects special accommodations, attention and unconditional acceptance. When you can't meet their unattainable expectations, you are vilified. Thus, the BP dramatically "splits" another person into all-evil and demonizes them as utterly uncaring, disappointing, abusive, incompetent, etc. These behaviors range from aggravating practice management experiences to crippling legal damage, for example as in false accusations of abusive, negligent or criminal acts levied against you. Remarkably, "splitting" can reverse itself suddenly. There is no predicting when you will be "split back" to sainthood; often this happens when the BP has left for another idealized relationship, only to return asking forgiveness when his/her new physician inevitably disappoints.

Criterion 5: BP patients have a short fuse for tolerating delay. Immediate self-gratification is a prominent issue. Thus, marked

Impulsivity is a striking criterion. It may be expressed in such life-threatening conduct as road rage and a predilection for aggressive public confrontation with authority figures, service persons or even strangers. It may manifest more subtly in the form of eating disorders and impulsive behaviors such as spending sprees or shoplifting.

Criterion 6: In many cases, a BP's fear of abandonment, perceptions of rejection, or poor impulse control precipitate inappropriate rage. Lacking a more differentiated capacity for expressing intense emotion, a person with BPD cannot **C**ontrol anger. Rages can come on with astonishing speed and violence, and are difficult to explain to anyone who is only nominally acquainted with the patient. Pediatricians should not dismiss as routine a patient's statement that "My Mom yells at me". Borderline anger is a terrifying experience for children. It is not "routine". To the child, it represents a trusted adult "out of control". These children truly have witnessed psychotic breaks that are traumatic events meriting intervention.

Criterion 7: Borderlines have what has been described as a chameleon-like persona: voice, gestures, clothing, opinions change according to the person or group from which they seek acceptance. Their self-presentation shifts from situation to situation. This reflects their underlying **I**dentity disturbance**.** BPs struggle with accepting themselves, thus histories of changing careers, religions, political parties and even sexual orientation are not unusual. They seek external validation of their self-value. They may seek friendship or intimacy with an "educated, successful physician" because it enhances their frail self-image. In effect, they acquire *your* admirable characteristics by successfully gaining acceptance from their healthcare provider.

Criterion 8: Dissociation is a state in which one becomes removed from reality. In BPD, psychotic symptoms such as dissociation, delusions and hallucinations, or paranoid ideation are *transient*. They appear when the patient is stressed or challenged. These patients dissociate—they do not remember their maladaptive behaviors. Their delusions tend to have some reality base and sometimes are termed "cognitive distortions" rather than true delusional thinking. That is, the patient's intense emotions *create* their facts. Paranoid ideation can include the temporary conviction that your medical care is illicitly harming them, loved ones are poisoning them, or quite commonly, you or another close relationship are disloyal and betraying them behind their back -- all despite considerable objective evidence to the contrary.

Criterion 9: Patients with BPD have a range of intense dysphoric affects. In addition to the rage and mood reactivity described above, some patients experience chronic feelings of **E**mptiness. This sense of emptiness described by sufferers represents an experience of boredom or numbness rather than actual depression.

It is helpful to appreciate that BPD, like asthma, is a life-threatening, chronic, *episodic* disorder. Much of the time, the condition remains masked until triggered by a stressor. During quiescent periods, we tend to misjudge these patients as normal individuals who occasionally act out. More precisely, these patients have demonstrable neurological lesions but many can maintain situational competency. Thus, the BP is fundamentally ill, but has developed the ability to mask his/her maladaptive behaviors. One should not diminish the graveness of the diagnosis because on casual clinical meeting, the patient is charming and composed.

In short, BP patients present with both cognitive distortions and emotional dysregulation. Effective clinical management requires an understanding of the common behavioral patterns.

The Behavioral Patterns

Mental health researchers have studied cognitive distortions common to BP organization. These include four ego defense mechanisms and several related emotional dysfunctions:

The Ego Defense Mechanisms: A useful acronym for recalling the four ego defense mechanisms of BPD is **SPRD** (**S**ome **P**eople **R**age **D**aily).

- **S**plitting
- **R**ationalization
- **P**rojection
- **D**enial

Practice Pearl 3: The DSM speaks of "unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation." This behavior in BPs is known as "splitting." In simple terms, those who aren't for them are against them. Since most of the world is truly gray, the borderline patient struggles with a serious cognitive difficulty in relationships. Thus, if you disagree with something they say, then merely by disagreeing you become a bad person. Consequently, your clinical relationships will be stormy. Once the patient's feeling of betrayal has passed, they may go back to seeing you as "all good" again.

Ego defense mechanisms are unconscious processes that protect people from disturbing emotions, thoughts or impulses.

Splitting: Kriesman [13] cogently describes the black and white cognitive patterns of BPD. *"The world of a BP, like that of a child, is split into heroes and villains. A child emotionally, the BP cannot tolerate human inconsistencies and ambiguities; he cannot reconcile another's good and bad qualities into a constant coherent understanding of another person. At any particular moment, one is either Good or Evil. There is no in-between; no gray area....people are idolized one day; totally devalued and dismissed the next".*

Practice Pearl 4: Simply stated, what the patient says about you is what they are really saying about themselves. A BP who is having thoughts of violence will feel that they are being threatened and will be paranoid that you are seeking to harm them physically. When the patient says, "You should really seek professional help", what they mean is, "I'm distressed but can't admit I need professional help." Understanding projection helps you to figure out what is going on with your BPD patient.

Projection: Projection is a derivative of Denial. The patient denies his/her own unpleasant traits, behaviors limitations, faults or feelings by attributing them to someone else. For example, a BP who is having thoughts of cheating, or who is actually cheating on his spouse, will accuse the spouse of infidelity. Someone with BPD may project their anger and believe that it is the *other* person who is angry. Since the BP cannot see his own role in interpersonal problems, he must blame the other person for whatever problems exist.

Rationalization: Is a defense mechanism the BPD patient uses to cast his/her misconduct in a favorable light after the fact. The patient will justify and explain his behaviors using: "rational, logical, socially-acceptable" explications and excuses. A borderline mother may tell the pediatrician, "My little girl, like all children, exaggerates about her bruises. I never lose my temper with my children and never hit

them. Occasionally, because this one is an "active child", I may have to gently swat her butt to prevent her from hurting herself". Thus, the BP copiously lies and rewrites history in an unconscious effort to disavow their misconduct or weaknesses.

Practice Pearl 5: Because these patients find it difficult to accept imperfection among them, they are reluctant to accept referral for mental health reasons. However, they often respond to a carefully worded referral such as: "We all have stress in our lives. I think it would be useful if you made an appointment with Dr. X about dealing with stress-related issues."

Denial: Denial is a finely honed defense mechanism for BPD patients. They are blind or uncritical of their own aberrant behaviors. They have limited insight into their disorder. They typically deny psychological problems or symptoms. *They invariably blame others for their problems.* These patients are unable to accept imperfection within them so they "externalize" their source of distress.

Emotional dysfunctions

- All or Nothing Thinking
- Emotional Reasoning
- Minimization
- Exaggeration
- Overgeneralization
- Personalization

All or None Thinking: Borderline patients rarely voice moderation. You are either an unsurpassed physician or criminally incompetent. They frequently tell of the virtues and atrocities of other physicians they have seen. They may seek your assistance in a lawsuit involving other healthcare professionals.

Practice Pearl 6: when such patients present with an intense medical or interpersonal problem appearing to require emergent action, it is particularly important for the clinician to follow the medical evidence rather than be drawn into the dramatic "emotional facts" detailed by the patient.

Emotional Reasoning: As a means of dissipating their intense internal distress, borderlines generate distorted information which fits how they feel. These patients accept only one view of reality—their own. Their *feelings* become their *facts*. They demand that you affirm the "truth" of their reality. Instead of seeking realistic information from their physicians, they contest contradictory information and seek to convince you that their cognitive distortions are true.

Minimization: Personality disordered patients can not admit their faults. They minimize what they have done. Common in those who commit domestic violence or child abuse, they cannot comprehend that their actions may have hurt someone. Thus, even parents who injure their children will explain away the concussion as "a bump on the head that is common when children play". The parent will likely blame the child for their own injury.

Exaggeration: In their attention-seeking behaviors, patients may convincingly exaggerate their symptoms. Such patients demand your full attention and sympathies. They persist until they feel comfortable that they are the center or your attention. Thus, their illnesses or injuries often are accompanied by detailed histories about their misfortune, exceptional or unusual circumstances and/or symptoms that escalate until the physician is satisfactorily entwined in their emotional turmoil.

Over Generalization: In this cognitive distortion, the patient takes an isolated observation and applies it to all instances. Speech such as "always" or "never" signals such distortions: "They always lose my lab work!" "You're never on time for my appointment!" are common examples.

Personalization: This is a type of cognitive distortion is one in which the patient interprets another's benign behavior as a personal threat. For example, the same medical bill mailed twice in one month is interpreted by the personality-disordered patient as the physician's" brazen and criminal attempt to defraud" them.

As your doctor/patient relationship develops with the BPD patient, you will observe many, if not all, of these cognitive distortions. Appropriate interpersonal responses will result in effective clinical management. Inappropriate clinical responses can be catastrophic to your practice.

Practice Pearl 7: Many clinicians consider a history of childhood abuse to represent the red flag leading to a diagnosis. Lieb's review article [8], points out that sexual abuse is reported in 40-71% of inpatients with BPD. Although BPD patients tend to deny a history of sexual abuse, they readily express that their children are being sexually assaulted in the manner they themselves experienced during childhood. The aforementioned ego defense mechanisms elucidate this interesting clinical observation. Pediatricians should be cautious when a parent presents their child and seeks validation that they have been sexually abused.

Etiology of BPD

Only recently, have researchers been able to correlate central nervous system anomalies with the patterns of dysfunctional behaviors in individuals with personality disorders. Several factors appear implicated in the emotional dysregulation, impulsivity and psychosocial conflicts exhibited by BPD patients. Childhood trauma such as neglect and abuse are believed to contribute to this disorder [8]. This environmental stressor along with invalidating parent-child interactions and genetically-linked personality traits are factors believed to contribute to the diagnosis of BPD.

Several recent studies reported anatomical and functional abnormalities of the amygdala, hippocampus, orbital frontral cortex (OFC), prefrontal cortex (PFC) and hypothalmus-pituitary-adrenal (HPA) axis in BPD patients [14]. These regions of the central nervous system are thought to monitor, evaluate and regulate emotion. The amygdala and hippocampus are two critical regions of the limbic system responsible for emotional regulation and memory. In BPD, there appears to be a reduction in size and increase in activity of the amygdala when compared to healthy controls [15,16]. The hippocampal volume is diminished as well [17]. Neuroimaging studies reference functional disruption of the PFC in BPD patients [18,19]. There also appears to be a dysfunction in the integration of right and left hemispheres in BPD. The finding of a smaller corpus callosum (the primary pathway for information exchange between hemispheres) in a sample of traumatized patients compared to controls, suggests an interesting correlate [20]. Thus, it is believed that BPD represents a compromise of neurophysiological function. Because these regions of the brain develop in early childhood, there appears to be support for childhood trauma as a strong etiological correlate of BPD. Genetics are thought to play a role as well.

Practical tips for managing the care of personality-disordered patients

If you understand the core issues of personality disordered patients, you can more effectively manage their intricate problems. Interpersonal bonding has been a life-long difficulty for them. A borderline's maladaptive behaviors are triggered by one or more of his/her four dominant emotional fears. (1) *Fear of abandonment* unleashes primitive rage. (2) Because of their fragile self-image, challenge or criticism sets off their *fear of inferiority*. The BP responds with anger, "put downs" and misplaced blame of others. (3) BPs are preoccupied with *fears of being dominated*. To feel in control in their relationships, they control others. They use cunning, lying, stealing, violence, and perseverant manipulation. They externalize these antisocial traits in the form of marked distrust of others. (4) Lastly, these patients *fear being ignored*. They constantly seek attention with dramatic and emotional demands. When their needs are unsatisfied, emotional outbursts ensue.

The following methods will help to manage the inevitable crises and manipulations in your clinical relationship:

Do not get too close: Physicians care. We like to help. It is self-satisfying to extend oneself with a patient who is especially charming, particularly smart, and appears to need us. It is tempting to do favors for this type of patient. Resist emotional involvement. Set firm boundaries. Avoid bending the rules. BPs regularly push limits by changing appointment times, telephoning after hours, bringing gifts, asking inappropriate favors, obtaining your home telephone and intruding on your time. Any sense of intimacy will lead the patient to develop intense feelings of love/hate for you.

Establish clear roles: BPs need to control their relationships. You, however, must remain the dominant authority. Firmly, but gently, outline your role and expectations. These patients do not like to submit to rules. You should emphasize that these rules are universal and apply to *everyone*. They will complain, but as long as they do not feel abandoned or singled out, they will comply to "stay in the relationship".

Avoid direct criticism: BPs cannot tolerate criticism. They feel compelled to respond and retaliate. They react by attempting to prove you wrong to have criticized them. They relieve their hurt feelings by seeking revenge for the perceived slights (suing for malpractice, badmouthing you, filing criminal complaints). It is best to approach your "difference in perception" with a positive comment validating the patient's feeling such as, "I understand how strongly you feel", or "That sounds serious". Validate the person, not his/her cognitive distortion. When you differ, emphasize that your medical decisions must be based solely on your findings rather than how the patient feels about the situation.

Avoid being swayed or biased by charm: BP patients present a finely honed likeable persona. In casual social relationships they say the right things. They quickly assess your politics, religious orientation, personal preferences and biases and become your "soulmate". Healthcare professionals such as physicians, nurses and social workers are easy marks. We like to be told we are helpful and compassionate. The BP exploits our sensitivity.

Document your interactions: Borderline patients seldom concur with your perception of events. Remarkably, they will insist on a position 180° divergent from your recollections often with threats in response to "your errors". Thus, document all phone conversations. Thoroughly notate any directions or referrals you give the patient. Make a record of seductive or provocative behaviors. Your notations should be objective, terse and non-judgmental. Anticipate your records will be subpoenaed in a legal proceeding. Encourage written interpersonal-communication because this serves as a permanent, irrefutable record.

Prognosis and treatment

Although the primary care physician does not provide treatment, it is important to know the currently accepted modalities for treating BPD. Personality disorders are largely refractive to treatment. By definition, a personality disorder is an *enduring, rigid and unchanging* pattern of behavior. The *overall* prognosis for borderline personality disorder is poor. Most BPD sufferers never receive treatment. The denial defense mechanism prevents them from admitting they have a problem. Thus for this subgroup, the success rate is zero. Other patients with BPD symptoms may *begin* therapy, but their impulsivity and difficulties with authority cause two-thirds of patients to cease treatment within months. For those patients who can remain in long-term therapy, remission rates as high as 50% have been reported [21].

Only certain types of psychotherapy and certain psychotropic medications are considered efficacious in the treatment of BPD [22]. Two psychotherapeutic approaches have been shown to have efficacy in randomized controlled trials: psychodynamic therapy and dialectical behavioral therapy (DBT). Both approaches are intensive long-term therapies. Psychodynamic techniques require partial hospitalization to demonstrate clinical progress. DBT necessitates one-hour individual weekly therapy plus 2.5 hours group therapy to demonstrate clinical progress. Economics and consumer acceptance mitigate toward DBT.

Although medications are widely used to treat patients who have BPD, the Food and Drug Administration has not approved any medications specifically for the treatment of this disorder. Nonetheless, pharmacotherapy is used to target certain aspects of BPD such as cognitive-perceptual symptoms, emotional dysregulation, or impulsive-behavioral dyscontrol [22]. For example, neuroleptics, such as clozapine (Clozaril), risperidone (Risperdal) and olanzapine (Zyprexa) have been used against cognitive-perceptual symptoms, such as suspiciousness, paranoid ideation, ideas of reference, or transitory (stress-related) hallucinations. Selective serotonin reuptake inhibitors (SSRIs) are considered as first-line agents in the treatment of the depressed, anxious, labile, dysphoric or angry BPD patient. In controlled trials, SSRIs such as fluoxetine (Prozac) and sertraline (Zoloft) have demonstrated greater efficacy and tolerability than other antidepressants (tricyclic antidepressants or monoamine oxidase inhibitors).

Although mood stabilizers such as carbamazepine (Tegretol) and valproate (Depakote) have been used in BPD patients with impulsive aggression and comorbid bipolar disorder, the controlled studies demonstrate mixed results [6].

Summary

Borderline Personality Disorder is a severe, chronic, disabling, and potentially fatal psychiatric condition. Patients who suffer with this disorder have extreme and long standing emotional instability. Their behaviors are maladaptive and such patients struggle with interpersonal relationships including the doctor/patient relationship. Compounding the seriousness of BPD, it is difficult to treat. The inherent characteristics of the disorder, such as unstable relationships and intense anger, interfere with establishing the therapeutic relationship that is necessary to any treatment, whether psychotherapy or medication. The family practitioner can benefit from an understanding of the characteristic manifestations of BPD and a mastery of the interpersonal skills needed to manage such patients.

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