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Editor's Note—*The term "borderline," originally coined by Stern in 1938,[1] was an effort to describe a group of patients who appeared neurotic, yet were prone to brief psychotic experiences. Stern conceptualized these individuals as literally existing between the borders of neurosis and psychosis, or on the "borderline." At the present time, borderline personality is conceptualized as a unique personality disorder highlighted by chronic self-regulatory disturbances and self-destructive behavior. This disorder is commonly encountered in the primary care setting and can be challenging both to diagnose and treat.*

Borderline Personality Disorder: The Enigma

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Description

Borderline personality is a personality disorder characterized by longstanding self-regulatory disturbances and self-destructive behavior. Examples of self-regulatory disturbances include difficulties with modulating eating behavior (anorexia nervosa, bulimia nervosa, obesity), substance use (prescription and illicit substance abuse), mood (chronic anxiety and/or depression), spending (over-extension on credit cards, gambling, bankruptcies), sexual behavior (promiscuity), and interpersonal relationships (boundary difficulties). Examples of self-destructive behavior include self-mutilation (e.g., cutting, burning, hitting oneself), suicide attempts, and physically abusive relationships. Despite pervasive deficits with self-regulation and repetitive self-destructive behavior, these individuals may appear extremely intact during brief superficial encounters. Hence, this particular personality disorder is characterized by the complex enigma of an intact social façade coupled with internal behavioral chaos.

Epidemiology

Prevalence. According to the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV), 2% of the general population suffers from borderline personality disorder (BPD).[2] However, Stone suggests that up to 10% of the general population may harbor symptoms of this disorder.[3]

Gender Distribution. According to DSM-IV, more women than men suffer from BPD.[2] However, our experience suggests fairly equal gender distribution—although females often display histrionic overtones whereas males display antisocial overtones. This impression is supported by other investigators, who indicate that gender appears to play an important role in the personality stylings, or axis II comorbidity, of individuals with BPD.[4] Zanarini et al found that males were more likely to demonstrate passive-aggressive, narcissistic, sadistic, and antisocial personality characteristics while both sexes demonstrated equal rates of dependent personality features.[4]

Socioeconomic and Educational Factors. We are not aware of any controlled studies specifically examining the socioeconomic and educational attainment of individuals with

BPD. However, BPD appears to exist along a continuum of functionality, from lower functioning individuals who populate state hospitals and community mental health centers to those at the opposite end of the continuum, with considerable educational and professional attainment.

Cultural Influences. Little research has been undertaken in the area of BPD and cross-cultural phenomena. Paris suggests that BPD is more prevalent in North America and Europe.[5] Comparing Western vs. Japanese cultures, Moriya et al found a lower prevalence of substance abuse among Japanese subjects with BPD, as well as greater enmeshment in masochistic relationships with parents.[6] In contrast, Ikuta et al concluded that borderline psychopathology is nearly identical among Japanese and American patients.[7] BPD may truly vary in prevalence from culture to culture, or it may be that the expression of BPD is modified through the influences of culture, resulting in different manifestations of the disorder in different cultures.

Etiology

Environmental and Genetic Factors. The explicit etiology of BPD remains unknown. However, in numerous studies, repetitive trauma (e.g., sexual, emotional, and physical abuse; witnessing of violence) by a caretaker during the early developmental years has been associated with BPD in adulthood.[8-14] Zanarini found early developmental trauma present in 85% of those with BPD.[8] Indeed, in examining four different approaches to BPD diagnosis, we found that those subjects with histories of abuse had a significantly greater number of BPD confirmations on study measures (core borderline disorder) compared with nonabused participants.[14] Not all studies support the childhood-abuse hypothesis.[15] It may be that other forms of abuse not examined in these studies play a significant contributory role and/or the unexpectedly high frequency of abuse in the general population may be washing out genuine relationships with BPD on a statistical level.

In addition to childhood maltreatment, there may be other contributory variables to the development of BPD among some individuals including a predisposing or vulnerable temperament,[16] traumatic triggering events,[16] inconsistent treatment by the caretaker,[17] and the patient's perception of a negative family environment.[18] While there may be a genetic contribution to BPD, this variable remains controversial.[19,20]

Biological Findings. Only a small number of studies have examined biological abnormalities among patients with BPD. Because of small sample sizes, their clinical significance remains unknown, but these studies may eventually confirm consistent contributory biological factors.

De la Fuente et al found hypometabolism in the premotor and prefrontal cortex of 10 patients with BPD.[21] Chotai et al reported higher cerebrospinal fluid levels of 5-HIAA and HVA among borderline patients with lower impulsivity scores, suggesting a protective function of serotonin against suicide and impulsivity in a subgroup of patients.[22] Among 20 borderline patients, De la Fuente et al found a 40% incidence of abnormal EEG studies characterized by diffuse, slow activity.[23] In a controlled study, New et al found that borderline patients (n = 14) had significantly lower serum cholesterol levels compared with 28 patients with other types of personality disorders.[24] Coccaro et al found, among personality-disordered subjects, biological abnormalities relating to impulsivity and aggression, including an inverse relationship with central serotonin and a direct relationship with cerebrospinal fluid arginine vasopressin.[25,26]

These biological studies are limited by small sample sizes and the lack of homogeneity among BPD samples. In addition, the reported correlations don't necessarily imply causality. However, these intriguing relationships may eventually lead to the identification of consistent biological abnormalities among those with BPD, some of which may, indeed, be causally related to symptoms.

Comorbidity

Psychiatric Comorbidity. Investigators have determined that, compared with others, individuals with BPD are significantly more likely to have multiple psychiatric (i.e., Axis I) diagnoses.[27,28] Not only is the number of Axis I diagnoses predictive for BPD, but a combination of mood disorder and impulse disorder diagnoses is particularly suggestive.[4] While the prevalence of most Axis I disorders appears similar for both males and females, males are more likely to have a lifetime diagnosis of substance abuse compared with eating disorders among females.[4]

In a population of 379 participants with BPD, Zanarini et al determined the lifetime prevalences of several Axis I disorders.[4] For anxiety disorders, the lifetime prevalence was 88%, major depression 83%, substance use disorders 64%, post-traumatic stress disorder 56%, eating disorders 53%, panic disorder 48%, dysthymia 39%, and somatoform disorders 10%. In contrast to non-BPD patients, those with BPD were more

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likely to be diagnosed with major depression, bipolar disorder, panic disorder, social or specific phobia, post-traumatic stress disorder, obsessive-compulsive disorder, eating disorder NOS, and any somatoform disorder.[4]

Medical Comorbidity. Few studies have explored specific medical conditions and their comorbidity with BPD. However, BPD has been associated with somatization disorder,[29] somatic preoccupation,[30] rheumatoid arthritis,[31] plastic surgery requests on multiple body areas,[32] and HIV infection.[33] Among male veterans, Streeter et al found traumatic head injury in 42% of those with BPD compared with only 4% among controls.[34] We are in the midst of a chronic pain study in a family practice setting and, to date, have found that nearly two-thirds of participants have BPD according to a highly structured interview (i.e., is chronic pain a self-regulation difficulty among some individuals?).

In the primary care setting, borderline patients may manifest self-destructive behavior in relation to their medical care. We found that a significant minority of family practice patients (7%) acknowledged the active sabotage of their medical care.[35] Reported behaviors included exposing oneself to an infected person on purpose, damaging oneself on purpose, misusing prescription medication to worsen a medical condition, not following directions given by medical personnel to purposefully prolong illness, and coming into contact with a known allergen to harm self. Medically self-harming behavior among patients in primary care settings has been empirically associated with borderline personality.[36]

Although the relationship of BPD to specific medical conditions and illness behavior is not well studied, patients with either trauma histories or borderline personality symptomatology appear to demonstrate greater health care use[37,38] (e.g., greater number of telephone contacts to the facility, physician visits, and prescriptions).[38] This observation may have a significant effect on the clinician's practice perspective, especially regarding the issue of capitation.

Diagnosis

The diagnosis of BPD in the primary care setting can be readily missed due to the brevity of office encounters and the intact social facade of these patients. Indeed, studies indicate that mental health clinicians under-diagnose BPD compared with researchers using structured interviews.[39] This observation underscores the importance of developing an effective diagnostic assessment strategy.

DSM-IV Criteria. The DSM-IV2 criteria for the diagnosis of BPD are shown in Table 1. These nine features provide the cornerstone for diagnosing borderline personality; confirmation of diagnosis requires that five or more features be present.

Gunderson Criteria. In conjunction with other investigators, Gunderson developed the Diagnostic Interview for Borderlines, which is a semi-structured research interview.[40] This interview contains five descriptive features for BPD that can be organized around the acronym P-I-S-I-A and adapted to the clinical setting (*see Table 2*). While not a substitute for the DSM-IV criteria, these five features describe the borderline syndrome quite well.

Because of their specificity, the features listed under "Impulsivity" and "Affect" are particularly useful as screening questions. In exploring impulsivity, the line of questioning might progress as follows: "Have you ever had anorexia, bulimia, or been obese? Have you ever had any drug or alcohol difficulties? Have you ever had problems managing money—credit card difficulties, gambling, or bankruptcies? Have you ever physically damaged yourself on purpose? For example, have you ever cut, burned, or hit yourself? Banged your head? Pulled out hair or eyelashes? Have you had any suicide attempts? Have you been in any abusive relationships? Have you engaged in any high-risk hobbies or behaviors?" With regard to affect, the question might be phrased: "Back to the age of 15, what percent of the time have you been in a normal mood—no depression, no anxiety, no emptiness, no anger?" Impulsivity is usually longstanding and may be characterized by symptom substitution over time. Characteristic responses to "normal mood since the age of 15" are typically 20% or less (*see Table 2*).

Table 1. DSM-IV Criteria for Borderline Personality Disorder

- Frantic efforts to avoid real or imagined abandonment
- A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation
- Identity disturbance: markedly and persistently unstable self-image or sense of self
- Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating)
- Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior
- 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)
- Chronic feelings of emptiness
- Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)
- Transient, stress-related paranoid ideation or severe dissociative symptoms

* *At least five criteria are required for diagnosis.*

Self-Harm Inventory. The Self-Harm Inventory (SHI)[41] is a self-report measure that can be used in the primary care setting to screen for BPD. It is based upon the concept that longstanding and multiple self-destructive behaviors are characteristic of BPD. In this regard, Gunderson and Singer noted that impulsivity and self-harm behavior were the two characteristics most commonly and consistently associated with BPD.[42] Indeed, Mack identified self-harm behavior as the behavioral specialty of individuals with BPD (i.e., the defining characteristic of the disorder).[43]

Developed among both psychiatric and primary-care populations, the SHI contains 22 yes/no items. Each item is preceded

Table 2. Gunderson Features for Borderline Personality Disorder

P ***Psychotic/quasi-psychotic episodes***: transient, fleeting, and brief in nature; may include depersonalization, derealization, dissociation, rage reactions, paranoia in which the patient subsequently recognizes the illogical nature of their suspiciousness, fleeting or isolated hallucinations or delusions, and unusual reactions to drugs; episodes tend to be persistent over the patient's lifetime.

I ***Impulsivity***: longstanding and ongoing; specific behaviors may be stable over time, co-exist with other behaviors, or replace each other over time (i.e., symptom substitution); impulsivity includes both:

Self-regulation difficulties: (e.g., eating disorders including anorexia and bulimia nervosa, and obesity; drug/alcohol problems; money management difficulties including credit-card difficulties, bankruptcies, and gambling; promiscuity; mood regulation difficulties).

Self-destructive behaviors: (e.g., self-mutilation such as hitting, cutting, burning, or biting oneself; suicide attempts; sadomasochistic relationships with others; high-risk hobbies such as parachuting or racing cars; high-risk behaviors such as frequenting dangerous bars or jogging in parks at night; recurrent accidents).

S ***Social adaptation***: superficially intact social facade; if the individual demonstrates high academic or professional achievement, performance is usually inconsistent and erratic.

I ***Interpersonal relationships***: chronically chaotic and unsatisfying relationships with others; the relationship style is characterized by "dichotomous relatedness," wherein social relationships tend to be very superficial and transient, and personal relationships tend to be extremely intense, manipulative and dependent; there may be intense fears of being alone as well as rage with the primary caretaker.

A ***Affect***: chronically dysphoric or labile since adolescence with the predominant affects being anxiety, anger, depression, and/or emptiness.

by the statement, "Have you ever intentionally, or on purpose…" Each "yes" response is scored (i.e., pathological). Using a cut-off score of 5, this measure was able to correctly identify 84% of subjects compared with the Diagnostic Interview for Borderlines.[40] We recommend using the SHI as a screening measure among those primary care patients with suspicious symptoms, noting that the cut-off score of 5 is suggestive of BPD (*see Appendix 1*).

Interestingly, there may be different behavioral manifestations of BPD in different medical-specialty settings. For example, using the SHI, we examined for differences among women with BPD in psychiatric vs. primary care samples. While most self-destructive behaviors were similar in prevalence among both samples, "overdosed" and "hit self" were more common in the psychiatric sample whereas "abused laxatives" was more common in the primary care sample.[44] These data suggest the possibility of behavioral differences among different populations of patients with BPD.

Presentations in the Primary Care Setting

Although the clinical manifestations of BPD in the primary care setting are varied,[45-47] in comparison with the psychiatric setting, the psychodynamics and diagnostic features remain constant. We have summarized some of the many possible presentations in Table 3. These presentations should be regarded as suspicious for, rather than diagnostic of, BPD and might function as an impetus to undertake a screening for BPD using P-I-S-I-A or the SHI.

In addition to the clinical manifestations of BPD, there may be a number of interpersonal dynamics that suggest BPD (*see Table 4*). Most of these dynamics reflect a very strong or overactive attachment drive to others,[48,49] which is characteristic of BPD. How these attachment dynamics relate to the etiology of BPD remains to be determined.

Management Suggestions

Conservative Medical Management. Investigators have noted among BPD patients greater frequencies of violence and maltreatment in adulthood,[50] which may relate to an underlying masochistic dynamic that develops as an outgrowth of childhood abuse. Through this dynamic, borderline patients may unintentionally lure physicians into inappropriate treatment (i.e., maltreatment). Examples of this include seducing the physician into the overprescription of medications (particularly analgesics, benzodiazepines, and weight-loss medications), multiple referrals for unnecessary surgeries including abdominal or plastic surgery, unusual treatment strategies (e.g., colonic irrigation, self-administration of analgesics via catheter, intrarectal administration of estrogen), and unnecessary and high-risk referrals (e.g., cardiac catherization).

Table 3. Possible Clinical Manifestations of BPD in the Primary Care Setting

- Chronic mood disorders (e.g., depression,[71] anxiety, mood lability)
- Impulse problems (e.g., eating disorders including obesity,[72] substance abuse, promiscuity, money-management difficulties)
- Self-destructive behavior (e.g., self-mutilation, multiple suicide attempts, abusive relationships, high-risk hobbies or behaviors, recurrent accidents)
- Multiple Axis I psychiatric diagnoses[27]
- Multiple sensitivities or self-reported allergies to medications[73]
- Extensive and chronic somatic preoccupation[30]
- Sabotage of medical care[35]
- Chronic pain syndromes[61,62]
- Exotic or "fashionable" medical syndromes (e.g., food allergies, chronic fatigue syndrome, fibromyalgia, multiple chemical sensitivities, hypoglycemia)[74]

Table 4. Interpersonal Dynamics That Suggest Borderline Personality Disorder

- Splitting (intrapsychic splitting: perceiving in absolutes or extremes; interpersonal splitting: polarizing others into conflict)
- Use of transitional objects[75] (i.e., the use of tangible objects), which are related or associated with another person, for soothing; (e.g., adults with teddy bears)
- Rapid transference (unexpected rapid emotional enmeshment with the clinician/staff)
- Tests of caring (e.g., unusual or impractical requests, such as unnecessary housecalls, designed to consolidate the patient as a favorite of the clinician; seduction into unethical behavior)
- First-name address (i.e., immediately addressing the clinician by the first name)
- Boundary violations (repeated attempts to enter into the clinician's professional or personal life; with the former, examples include repeated calls and appointments; with the latter, examples include obtaining the clinician's beeper or home telephone number, stopping by the clinician's house, performing special service activities for the physician to foster attachment)
- Intermittant childlike demeanor (evidence of periodic regression such as a childlike voice and/or regressed appearance)
- Crisis-oriented professional relationship (i.e., frequent personal crises and tragedies requiring calls to and appointments with the clinician)

Defined Treatment Plan. At the outset of a new-patient encounter, define your practice standards and established treatment approach to the patient's primary problems. This may precipitate the negotiation of medication weans, new drug trials, and different types of interventions. Avoid accommodating borderline patients at the expense of your own medical comfortability. Always carefully document your proposed treatment plan in the medical record to avoid any misinterpretation by the patient, staff, or cross-covering physicians.

Firm Boundaries. Maintain clear and consistent professional boundaries with the patient. Retain a neutral emotional tone during encounters, particularly during conflict situations. Avoid informality, when possible, such as hallway chats. Be prepared for and avoid the accommodation of unusual requests (e.g., stopping by the patient's home to drop off a prescription).

Structured Office Environment. Maintain a stable and consistent office environment for the patient. This may entail having the same nursing staff, the same employee in the business office, and the same physician work with the patient whenever possible. It may even be helpful to use the same examination room.

Accomodation of Attachment Needs. Anticipate the attachment demands of these patients. They may require multiple brief office visits to sustain their own stability. Keep appointments brief, if possible, but be sensitive to their needs to secure an attachment with you.

Limit Setting. Be prepared to establish limits, and to do so in a supportive fashion. Because of the self-regulatory disturbances of these individuals, they will ultimately require various types of limits in their relationships with others. Anticipate this process, establish limits quickly when difficulties emerge, and frame those limits as "an effort to protect our professional relationship and keep it functioning smoothly." Framing a limit in the context of attachment is usually an effective method for supporting the borderline patient.

Avoidance of Sensitive Psychological Issues. Be hesitant to explore psychological issues in an in-depth manner. Psychological exploration in any individual, borderline or not, results in some degree of regression, and borderline individuals may regress precipitously. When complex psychological concerns arise (e.g., abuse dynamics, suicidal thoughts), clarify your professional limits and suggest a referral to a mental health professional.

Use of Psychotropic Medication. Should the patient express concerns about depression and anxiety, consider limited psychotropic intervention. There is no known drug or drug combination specifically for BPD. In the field of psychiatry, many clinicians advocate a symptom-specific approach (i.e., antidepressants for depression, anticonvulsants for impulsivity, antipsychotics for pronounced quasi-psychotic phenomena).[51,52]

In the primary care setting, the use of SSRI-type antidepressants appears to be a conservative intervention as these medications have mild side effects; are safe in overdose with the possible exception of citalopram;[53,54] and have positive effects on mood, impulsivity,[55-57] and post-traumatic stress symptoms.[58] (Among psychiatric prescribers, SSRIs may be recommended in high doses.)

An additional conservative medication strategy might include the prescription of gabapentin.[59] Gabapentin may be prescribed either as an augmenting agent (i.e., enhancing the effects of the primary medication), or for the intervention of specific symptoms such as panic, anxiety, or impulsivity.

Medication trials in borderline patients are typified by medication sensitivity, idiosyncratic responses to medications, and partial responses. Begin psychotropic medications at low dosages and advance slowly. Anticipate potential problems with side effects. Should the patient not experience meaningful benefit, suggest a referral to a psychiatrist, framing the referral as "the need to consult a specialist in psychotropic medication."

In the primary care setting, we would advise caution with benzodiazepines (self-regulatory difficulties may lead to addiction; alprazolam has been associated with behavioral dyscontrol in BPD patients[60]), tricyclic antidepressants or lithium (impulsivity may result in a lethal overdose), combinations of psychotropic medications with not-yet studied effects (e.g., SSRI and a tricyclic-risk of drug interactions via the P-450 isoenzyme system), and multiple psychotropic drugs (e.g., antidepressant, anxiolytic, hypnotic, mood stabilizer, and antipsychotic).

Acceptance of Limited Symptom Resolution. Be alert to the complex medical complaints of many of these patients. Consider that full resolution of symptoms may not occur as medical complaints may function to secure an ongoing attachment to the clinician. On the contrary, antidepressant treatment, including SSRIs and venlafaxine,[61,62] may diminish somatic

symptoms among some patients.

Acceptance of Personal Limits. Recognize your own limits. These challenging patients can be highly stressful. A personal consultation (formal or informal case review of difficult patients) with a mental health professional may assist the clinician in the management of these difficult patients.

Psychiatric Referral. Psychiatric referral can be helpful in a number of ways including the confirmation of a BPD diagnosis, pharmacological management of the patient, and assessment for psychological treatment options. In general, lower functioning patients are limited to supportive-maintenance treatment, which consists of assisting individuals with daily life tasks and here/now problem-solving. Higher functioning patients may be candidates for psychodynamic psychotherapy.

Outcome

There is little available outcome research in the area of BPD. In examining the issue of suicide, Gunderson found that 75% of patients acknowledged attempts.[63] Concurrent mood disorder and/or substance abuse appear to heighten the risk of attempts.[64] As for completed suicide, studies indicate that the rate increases with the length of follow-up, with up to 10% of patients suiciding over a 20-year period.[65-67] Better prognostic outcomes are associated with comorbid obsessive-compulsive features and those with eating disorders.[68] A history of sexual abuse[69] and high levels of impulsivity and poor premorbid functioning[70] are associated with poor outcomes. In our experience, those individuals with antisocial features also have poor outcomes. We are aware of no studies examining medical outcomes (e.g., diabetes, hypertension) among primary care patients with BPD.

Conclusion

The diagnosis and management of BPD patients in the primary care setting is a genuine challenge. Strategies include being alert to the associated clinical features (i.e., self-regulation difficulties, self-destructive behavior), consolidating a diagnostic approach, and maintaining a conservative and structured clinical interface. These individuals can be difficult patients, but can be managed in the primary care setting with patience and perserverance. Regardless, they remain true enigmas, with their intact facades concealing the genuine turmoil that lies beneath the social surface.

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Physician CME Questions

67. Regarding etiology, borderline personality disorder may be caused by:
    a. repetitive trauma in early childhood.
    b. an unsupportive family environment.
    c. vulnerable temperament.
    d. genetic predisposition.
    e. All of the above

68. In the primary-care management of borderline personality, all of the following are true *except*:
    a. referrals should be conservative.
    b. the primary care physician should avoid prescribing any psychotropic medication.
    c. boundaries with patients should be carefully monitored.
    d. exploration of sensitive psychological material should be avoided.
    e. during new-patient encounters, the treatment strategy should be carefully defined at the outset.

69. Regarding the use of psychotropic medication in patients with BPD:
    a. benzodiazepines are generally recommended.
    b. SSRIs have broad clinical use.
    c. polypharmacy in the primary care setting is the general rule.
    d. lithium is generally advised.
    e. tricyclic antidepressants are routinely recommended.

70. Regarding the outcome of patients with BPD:
    a. most borderline patients will eventually commit suicide.
    b. 2% of borderline patients commit suicide over a 20-year follow-up period.
    c. 10% of borderline patients commit suicide over a 20-year follow-up period.
    d. 25% of borderline patients commit suicide over a 20-year follow-up period.
    e. borderline patients rarely attempt or complete suicide.

Readers are Invited. . .

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