

Borderline personality disorder – a misunderstood disorder

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Personality disorders impact up to 6% of people in the community (1). Of these, borderline personality disorder (BPD) is the most commonly diagnosed. It is also among the most severe of all personality disorders (2). Studies conducted in Western countries report that BPD impacts at least 1% of the population (3-5). The representation of BPD increases in clinical settings, affecting 15% to 20% of patients in mental health services and 6% of patients in primary care (6-9). Despite its high prevalence, BPD remains a highly stigmatised and misunderstood disorder. This is encapsulated in a quote from Professor John Gunderson, a pioneer and visionary in the field, who once stated that “*BPD is to psychiatry, what psychiatry is to medicine*” (10).

BPD is characterised by instability in mood, relationships and self-identity, together with impulsivity, fear of abandonment, anger dyscontrol, recurrent suicidal and self-injurious behaviours, episodes of dissociation and micro-psychosis. Some patients with BPD may experience severe and persistent self-loathing, chronic hopelessness, emptiness and “*identity-less-ness*” (11). BPD is a complex mental illness with significant morbidity and mortality. About 85% of patients self-injure. People with BPD are chronically suicidal; the suicide rate for BPD is 10% (12). When their illness is active, people with BPD endure miserable and painful lives. Chronic suicidality appears to be used as a coping strategy. People with BPD often experience life to be so painful that maintaining suicidal ideations helps them to stay alive (13). BPD contributes to about 95% of all personality disorder-related suicides (14).

BPD has a wide impact, causing significant distress to patients, families and friends. Clinicians working to support people with BPD may also experience distress and significant emotional reactions. BPD tends to co-occur with other psychiatric disorders such as depression, post-traumatic stress disorder, eating disorders and substance use disorders. The presence of BPD negatively impacts the prognosis of co-occurring psychiatric disorders, particularly depressive disorders (15). Co-occurring psychiatric disorders respond less well when treated separately in the absence of treatment of BPD with specific psychotherapies. Certain medical illnesses also tend to co-occur with BPD, with a third of

BPD patients having chronic pain conditions (16) while a third of women with BPD have polycystic ovarian syndrome (17). The prevalence of metabolic syndrome, obesity and chronic fatigue syndrome is also significant. Overall, the life span of a person with BPD may be reduced by up to 20 years (18).

The study of BPD has attracted significant global interest during the last three decades, resulting in a vast body of research. As a result, several misconceptions about BPD have been corrected. One of these is the myth that BPD is a disorder of women; it is now clear that BPD impacts both genders equally (3).

BPD impacts people across their life span. Although BPD usually emerges during adolescence (19), it is often not diagnosed until the age of 18. Therefore, opportunities for early intervention are often missed. Recognising the need for early diagnosis and intervention, the Australian National Health and Medical Research Council (NHMRC) clinical practice guideline for the management of BPD has recommended that BPD be diagnosed from the age of 12 (20). Some recent reports have noted that BPD symptoms can persist beyond 65 years of age or manifest for the first time in later life (21).

Recent studies have improved our understanding of the etiology of BPD. The genetic heritability of BPD is believed to be about 50% (22). This impacts the expression of brain mechanisms that are involved in emotion regulation. Biological abnormalities such as hyperactive amygdala, poor executive control of the amygdala via prefrontal cortical pathways, anterior insula abnormality (causing profound incapacity to co-operate) have all been reported. In the past, childhood trauma was considered to be a causative factor in the development of BPD. Although trauma is very common in BPD, it appears to be a risk factor rather than being essential for the development of BPD. Complex interactions between biological vulnerabilities and environmental factors (e.g. trauma, attachment disorders, bullying, invalidating interpersonal experiences during developmental years) may result in individual patients carving their own unique pathways towards the development of BPD. The Australian NHMRC Guideline (2012) concluded that “*having BPD is not the person’s own fault – it is a condition of the brain and mind*” (20).



The diagnosis of BPD was previously thought to have a poor prognosis; clinicians held a pessimistic view about its treatment and clinical outcomes. Clinicians often hesitated to give patients a diagnosis of BPD, fearing the stigma and discrimination that patients would experience. When clinicians did make this diagnosis, they often avoided discussing this with their patients because of its pejorative name, perceived lack of treatment and poor prognosis.

Two key longitudinal follow-up studies, the Collaborative Longitudinal Personality Disorders Study (23) and the McLean Study of Adult Development (24) have dispelled the belief that the prognosis for BPD is poor. The prognosis is optimistic for patients with BPD; the evidence tells us that most people with BPD will eventually achieve a life worth living, find their place in the world and stop wanting to kill themselves (23). Most patients can achieve symptomatic remission when appropriate psychological treatments are provided. However, recovery (having at least one meaningful relationship and being able to work) may take longer and be more difficult to achieve. Once remission is achieved, relapse rates are as low as 15% (18).

Psychotherapy is the treatment of choice for BPD. As yet, no psychotropic medications have been patented or indicated for the treatment of BPD despite their widespread use for treating BPD symptoms. Psychotropics may at best be used for short-term, time limited crisis management or as adjuncts to psychotherapies. There is a wide range of evidence-based psychological treatments for BPD, however the “big four” remain the most popular. The big four treatments include Dialectical Behaviour Therapy (DBT); (25), Mentalization Based Treatment (MBT), Schema Focused Therapy (SFT) and Transference Focused Therapy (TFP). These are highly specialized BPD-specific treatments that can help patients achieve remission from BPD. Although these highly specialized treatments are effective, they are expensive to deliver and clinicians providing these treatments require extensive and intense training. Therefore, these treatments are less suitable for a national population health approach. However studies have demonstrated that BPD-specific generalist treatments such as General Psychiatric Management, Structured Clinical Management, and Good Clinical Care are as effective as the specialist treatments (26). Research has highlighted the commonalities among specialist and generalist treatments, leading to the development of integrated, common factors based, stepped-care treatments that can be adapted to local mental health systems (26).

BPD in the context of Eastern cultures:

There is paucity of definitive epidemiological data about the prevalence of BPD in Eastern countries. However,

interest in the detection and treatment of BPD is gathering momentum in these countries as the impact of untreated BPD is recognised. The stigma around BPD is likely to be significant in many Eastern cultures given the prevalent stigma around suicide and self-injury, hallmark features of BPD. In countries where mental health care is not widely accessible, treatment of BPD is likely to pose a big challenge. Most of the evidence-based psychological treatments for BPD were developed in Western countries for Western populations in the context of individualistic cultures. It is not clear whether these treatments are the best options for Eastern countries, where collectivistic cultures are common.

Veerasamy et al., (27) suggested that the focus in developing countries should start with collecting epidemiological data related to BPD and then improve service delivery, create more awareness, identify and diagnose patients with BPD, develop treatment guidelines, and train clinicians in psychological therapies. Looking to the future, prevalence studies need to be undertaken to establish how BPD may manifest in Eastern countries. The symptom profile of BPD may turn out to be somewhat different, reflecting cultural differences. Treatments such as DBT and Acceptance and Commitment Therapy that have roots in Buddhist mindfulness traditions may render themselves more adaptable to Eastern contexts. Psychological interventions that actively include family members alongside the person experiencing BPD and have been adapted to local cultural contexts will need to be developed and tested.

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