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Snips from the Journals

What is new in borderline personality disorder?

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Aetiology and management of borderline personality disorder (1)

In October 2021, Professor Bohus and colleagues published a seminar on borderline personality disorder in The Lancet (1). They state that much progress has been made in understanding and managing borderline personality disorder since the term was first coined by Adolf Stern in 1938, and its first entry to DSM 3 in 1980 (1). Further, they describe that borderline personality disorder (BPD) as a severe mental disorder affecting three main psychological domains; pervasive patterns of emotional dysregulation, inconsistent identity and disturbed interpersonal functioning – although presentations can vary significantly between individual sufferers and over the life span (1).

Bohus et al, explain that symptoms of BPD first appear in the early adolescence, peak in the late adolescence and early adulthood and declines thereafter (1). The lifetime prevalence of BPD is 2.7%, while the community prevalence of BPD is reported to be around 2-3% among adolescents and 0.4% among people above the age of 40 years (2,3). Prospective studies indicate suicide rates among those with BPD to be 2-6%, and that women appear to have a poorer prognosis compared to men (4). Those with BPD have high life time risks of developing disorders of anxiety, mood and substance use disorders, with rates of 84.5%, 82.7% and 78.2% reported, respectively (2). Evidence suggests a genetic overlap between BPD and several other mental illnesses including, bipolar disorder, major depression, and schizophrenia (5). Research evidence for neurobiological underpinnings of BPD suggest disturbances in corticolimbic circuitry and involvement of the hypothalamic pituitary adrenal axis, serotonergic and other neurotransmitter systems such as glutamate, GABA and opioid pathways, but these findings need replication (1).

The diathesis stress model has been proposed to delineate how environmental factors impact on the development of emotional regulation, social cognition, and adaptive identity function in BPD (6). Bohus et al, report that stress related dissociative phenomena such as depersonalisation, derealisation, and reduced pain perception are common among sufferers, and associated non-suicidal self-injury may occur as a means for reducing tension and terminating dissociation (7). Despite earlier reports of BPD running an intractable course, recent studies report remission rates among 60% of patients with BPD (8).

Bohus et al, recommend psychosocial interventions as the first line of treatment in BPD and strategies addressing crisis behaviours such as suicide attempts, and other high-risk behaviours need interventions based on functional behavioural analysis, taking into account factors such as vulnerability, triggers and maintaining factors (1). Bohus et al, also highlight the importance of offering the following aspects in management:

- Outpatient interventions whenever possible, reserving in-patient interventions for life threatening situations and for the shortest possible time frames.
- Dialectical behavioural therapy (DBT) and mentalisation-based treatment as they are shown to be effective – DBT shows a steeper decline in self harm and emotional dysregulation. In addition, group treatment in DBT has also been shown to have good therapeutic effects.
- Transference Focused Psychotherapy (TFP), Schema Focused Therapy (SFT), Systems Training of Emotional Predictability and Problem Solving (STEPPS), when available. However, when such facilities are not available, mental health professionals are recommended to offer psycho-education, other psycho-social interventions, self-help material and an outpatient crisis intervention plan.

Bohus et al, mention that medication should only be used as an "add on" to psychosocial measures, and polypharmacy should be discouraged. These authors highlight that any treatment programme for BPD should involve educating the patient, as well as educating and supporting family members and training them in interpersonal behaviour management (1).

High comorbidity between borderline personality disorder and substance use disorders (SUD) (9)

The common co-occurrence of borderline personality disorder and substance use disorders (SUDs) has been described for decades (10). Trull et al, reports that the co-occurrence with SUD is seen among both clinical and the community samples (9). Approximately half of those

with BPD have been found to have at least one current SUD, most commonly alcohol use disorders (9). Trull et al, also mention that among those with a current SUD, approximately 25% meet criteria for BPD (9). Authors also observed, "those with a current opioid, cocaine, and alcohol use disorder most frequently received a BPD diagnosis" (9).

Theories suggest that emotion dysregulation as well as impulsivity figure prominently in the development of both disorders (11 ,12). Furthermore, the co-occurrence of BPD and SUD may reflect the common etiological processes, with early expression of impaired impulse control and affective dysregulation in both these conditions (11). These findings, in concert with reviews of the phenotypic associations between borderline personality traits (BPTs), BPD and SUDs, suggest that the domains of emotion dysregulation/affective instability and impulsivity might be targets of both etiological research on these conditions, as well as treatment research that seeks to identify underlying vulnerabilities that serve to increase risk for these disorders (9). Unfortunately, despite the promise of Dialectical Behavior Therapy in treating BPD, only a few randomized controlled trials have directly assessed the effects of treatment on SUD-related problems in those with BPD (13). It is reported that, to be successful in reducing substance abuse and substance-related problems associated with BPD, treatment needs to be modified to focus on and target specific influences that promote substance abuse in such patients (14).

Involving trained volunteer family members, crisis management, reduction in family conflicts, and addressing family members' psychological problems to achieve patient recovery and better family dynamics (15)

Guillen et al, highlights the suffering of family members and carers of people with BPD, due to their dysfunctional patterns of behaviour (15). Common psychological issues experienced by family members include; exhaustion, distress, grief, anguish, depression, burnout and having to cope with disruption to their daily life (15). Guillen et al, reports interventions that enable family members to set limits, validate their own experiences, and in turn, exert a beneficial influence on the patient (15). The National Institute for Health and Care Excellence (NICE) guidelines for BPD treatment has highlighted the need to provide interventions for family members as a key aspect of the BPD management (16).

In a family oriented study, Pearce et al, in 2017 explored intervention based on CAT and general psychiatric care applied by expert clinicians among family members (17). Results showed significant reductions in subjective burden (17). Grenyer et al, in 2018 offered the "Staying Connected" programme which offered 16 hours of face-to-face contact over 10 weeks, along with a psycho-educational DVD, as compared to an await list control (18). They showed that the intervention group had more family empowerment, dyadic perception, and reduction in family criticism compared to a waiting list control group. In addition, Bateman and Fonagy have shown that mentalisation based programs provide family members with improved family functioning and wellbeings (18).

Further in the "Family Connections" (FC) study, Hoffman et al, look into the efficacy of DBT based family interventions with several follow up studies, and showed significant decrease in disease burden, perceived discomfort, depression and distress and significant increase in participants' subjective experience in mastery and empowerment, which were maintained at follow up (19) (20).

Use of psychotropics as an adjunct to treat symptoms of BPD (21)

The National Institute for Health and Care Excellence (NICE) guidelines state that antipsychotic drugs should not be used for the medium- and long-term treatment of BPD (22). They advise clinicians to consider drug treatment in the event of a crisis, but that these should be prescribed for no longer than 1 week (22). The same guidelines state that, when considering drug treatment for any reason for a person with BPD, clinicians should consider the existing evidence regarding the efficacy of target drugs and inform patients (22). The guidelines of the American Psychiatric Association recommend a symptom-targeted pharmacotherapy, consistent with the conclusion that psychotropics do not change the overall severity of the disorder (23).

Del Casale et al, in their systematic review report that different serotonergic antidepressants (such as duloxetine, fluoxetine, fluvoxamine and venlafaxine) and atypical antipsychotics could be safe and effective for the treatment of mood symptoms, anxiety, and impulse control in BPD (21). Further, they conclude that atypical antipsychotics such as olanzapine, risperidone and quetiapine can be useful in the treatment of psychotic and dissociative symptoms, and that antiepileptics can be useful in treating instability of mood, impulsivity and poor anger control in patients with BPD (21).

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