



Improved prognosis for borderline personality disorder

New treatment guidelines outline specific communication strategies that work

Brin F S Grenyer
BA (Hons), MSc, PhD,
Professor of Clinical
Psychology

School of Psychology, and
Illawarra Health and
Medical Research Institute,
University of Wollongong,
Wollongong, NSW.

grenyer@uow.edu.au
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Until recently, borderline personality disorder (BPD) was considered to be a chronic ongoing condition with a poor prognosis and no effective treatment. However, the tide of research and clinical opinion has turned, and the prognosis for this disorder is now considered improved for most patients if one of a number of effective evidence-based treatments is implemented.¹ On 15 March 2013, the National Health and Medical Research Council (NHMRC) issued the *Clinical practice guideline for the management of borderline personality disorder*, which outlines best practice.²

BPD was first described in 1938 when referring to a recognised group of people who were thought to be on the “borderline” between neurosis (depression and anxiety) and psychosis (schizophrenia).³ The term “borderline personality disorder” became accepted medical terminology in 1980 with its inclusion in the third edition of the American Psychiatric Association’s *Diagnostic and statistical manual of mental disorders*.² The prevalence of BPD in the community is between 1% and 4%, but at least one-quarter of all mental health presentations to emergency departments or inpatient mental health units are people with a personality disorder.⁴

People with BPD may try to avoid abandonment by others, and they may have intense and unstable relationships, and feelings of insecurity and emptiness. They have difficulty with emotional regulation, manifesting as low mood, sudden anger, irritability, detachment and impulsivity in activities such as using drugs or engaging in risky sexual activity. The illness may include both anxious and labile mood, along with occasional more severe components such as transient stress-related psychotic-like symptoms, including paranoid delusions or hallucinations.

BPD is currently understood to be caused by a combination of biological factors (eg, genetic interpersonal hypersensitivity) and early environmental influences (eg, adverse childhood experiences).⁵ It cannot be said that BPD only derives from post-traumatic stress.⁶ Therefore, in view of current understanding, it is not “the person’s fault” or a result of “personal weakness” or “being manipulative” — labels that are sometimes prompted by the negative reactions of health care workers to people with the condition.

Clinicians are familiar with the problem of young people who self-harm, or who present as needy and impulsive, and who have a history of presenting to emergency departments in crisis. Managing these people can be a challenge, in part because they often have difficulty describing themselves.^{7,8} Such people can present sometimes as aggressive, entitled and disinhibited, but at other times as needy, timid and compliant. It is important to recognise that self-harm does not indicate BPD if it is the only presenting problem.

Psychological therapies are the treatment of choice. Over 25 randomised controlled trials have now demonstrated the

benefits of specific types of psychotherapy that are known to be effective, such as dialectical behavioural therapy, mentalisation-based therapy, and transference-focused therapy.³ An important factor that is common to all effective therapies is the use of a specific form of communication focused on discussing current relationship difficulties and methods of problem solving with patients, so that they are able to choose healthier relationships and maintain study and work.⁹ Clinicians should avoid discussing past traumas in the early stages of treatment, as this has rarely been found to be helpful and usually worsens patients’ mental health and increases their risk of suicidality. Unlike depression, anxiety or schizophrenia, there are currently no approved medications that are “on label” indicated for the disorder, with Recommendation 11 of the NHMRC guidelines stating that “medicines should not be used as primary therapy for BPD, because they have only modest and inconsistent effects, and do not change the nature and course of the disorder”.²

Effective treatments aim to strengthen self-esteem, and use the therapist–patient or doctor–patient relationship to provide a “safe place” for the patient to discuss alternatives to destructive behaviour and relationship insecurities, with an unhurried, step-by-step “here and now” approach to improve daily functioning. One of the principles of the NHMRC guidelines is that to be effective, doctors should try to “act consistently and thoughtfully ... to make sure the person stays involved in finding solutions to their problems, even during a crisis”.^{2,10} The availability of resources to help doctors, patients and their families and carers to understand and better respond to the condition is important; the NSW Health Project Air Strategy for Personality Disorders¹⁰ (www.projectairstrategy.org) referred to in the NHMRC guidelines is an example of such resources being made available in one place. People who suffer from the disorder almost always experience receiving a diagnosis as helpful, because it allows them and their families to understand that this is a recognised disorder and that there are good psychotherapies that provide hope.

A major focus of effective treatment is to support families, partners and carers of people with BPD.² Because of the interpersonal nature of the disorder, families often feel burdened by their relative’s condition, and also need to learn effective ways to communicate and cope with living with a person with the illness. The doctor or therapist can encourage families to stay connected to the person with BPD, even though this may be stressful.¹⁰ Doctors and therapists have an important role in supporting both patients and families to get the help they need, and in providing education about the latest developments in our understanding of the disorder. Most of all, doctors and therapists are in a powerful position to give hope to those with the diagnosis, and to work to overcome the stigma

and prejudice surrounding BPD. This is particularly important, as people with the condition are now known to respond well to new treatments.

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Stamps of greatness

Jean-Martin Charcot (1825–1893)



CHARCOT was born in Paris, France, on 29 November 1825 and studied medicine at the University of Paris. He graduated in 1853 with a thesis on polyarteritis nodosa and, in 1862, became physician to the famous Salpêtrière Hospital, where he worked for 33 years.

It was here that he created, from small beginnings, the greatest neurological clinic of modern times, to which students flocked from all parts of the world.

He was a great clinician in the broadest sense of the word, careful of the patients committed to his care, wonderfully energetic and diagnostically acute, though in his examination of hysterical patients he is now thought to have produced symptoms sometimes by the suggestive nature of his questioning.

Charcot was not only a great neurologist, but also made his mark early with his lessons on senile and chronic diseases (1867) and diseases of the biliary passages, liver and kidneys (1877). He described many diseases such as hysteria, muscular atrophy, amyotrophic lateral sclerosis, multiple sclerosis and paralysis agitans.

He differentiated between neuroses and psychoses, and described the locomotor ataxia, gastric crisis and joint lesions of syphilis.

He has given his name to many diseases and conditions such as “Charcot’s disease” and “Charcot’s joint”. With his pupil Pierre Marie (1853–1940) he described peroneal muscular atrophy in 1886. This was also described by Howard Henry Tooth (1856–1926), and is so known as Charcot–Marie–Tooth disease.

Charcot’s lectures at the Salpêtrière from 1872 to 1893 were published and later translated into English by the Sydenham Society in 1881.

Charcot was also an artist of some renown and founded the *Iconographie de la Salpêtrière*, which is still being published. With Paul Richer he published two fascinating monographs on demonomania in art (1887), and on the deformed and diseased in art (1889).

Like Babinski after him, he regarded hypnosis as a neurotic condition, akin to, if not identical with, hysteria, and waged a long battle with the Nancy School as to the part played by suggestion. The soundness of his

views was borne out by the later tendency to merge the procedure into psychotherapy, of which he was a pioneer.

Charcot died in Morvan, France, on 16 August 1893 from a probable myocardial infarction, and was postally honoured by France as a great physician in 1960.

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Robert Barany (1876–1936)

BARANY was born in Vienna, Austria, on 22 April 1876, and studied medicine at the University of Vienna, graduating as a physician in 1900.

He went on to do postgraduate studies at several other universities and then became an assistant to Adam Politzer, one of the pioneers of otology, at the Vienna Ear Clinic.

There he began his detailed studies of the inner ear and, in 1906, developed the caloric reflex test for nystagmus, now known as the Barany test, for evaluating the function of the semicircular canals.

In 1911 he described the Barany syndrome of vertigo, occipital pain and unilateral deafness. He also developed the Barany chair for evaluating aeroplane pilot stability, and devised the Barany box or “noise machine” for testing paracutic hearing.

He helped to differentiate Ménière’s disease, or aural vertigo, from epilepsy (1906). He was awarded the 1914 Nobel Prize in Physiology or Medicine for his work on the physiology and pathology of the vestibular apparatus of the ear.

While serving as an army surgeon in World War I, he was captured by the Russians but was released in 1917, after the intervention of Prince Carl of Sweden. He then went on to become professor of otology at the University of Uppsala in Sweden.

In 1924 the Swedish Karolinska Institute conferred an honorary doctorate in medicine on him. In 1927 he was made a Commander of the Northern Star, first class, by the King of Sweden.

He died on 8 April 1936 in Uppsala, and was honoured philatelically by Sweden in 1974 in its Nobel Prize winners series of stamps.

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