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Crossing the Borderline

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The Case

A 24-year-old woman with borderline personality disorder was admitted to an inpatient psychiatry unit following a failed suicide attempt with excess doses of acetaminophen. The patient had a history of suicide attempts, including episodes of self-inflicted trauma and abusive behavior. Upon admission, the patient was isolative, displaying a flat affect and expressing a desire to harm herself. When her mood significantly improved after several days of restricted activities, the care team provided her with more freedom, hoping it would improve her condition. Despite occasional gestures suggesting ongoing risk for self-harm as well as continued conflicts with the care team, the patient's behavior became focused on a home visit for her upcoming birthday.

As the care team had observed nearly 72 hours of appropriate behavior, the day before her birthday, they granted permission for the patient's request. Later that evening at home, the patient set herself on fire, prompting immediate return to the hospital for necessary treatment. The events prompted a review and a strengthening of the policies regarding formal risk assessment in this patient population.

The Commentary

Borderline Personality Disorder (BPD) is a disorder with an age of onset between 18 and 25.(1) It is categorized in the dramatic/emotional/impulsive cluster of personality disorders; diagnosis is made when five of nine DSM-IV-TR (2) criteria are met (Table), and the prototypic patient with BPD shows a pervasive pattern of instability of mood, impulse control, interpersonal relationships, and self-image. The prevalence of BPD is estimated to be between 1% and 2% in the general population (3), 6% in a primary care population (4), and between 10% and 20% of psychiatric outpatient and 15% and 20% of psychiatric inpatient populations.(5) Common comorbidities include mood disorders, anxiety disorders, eating disorders, substance use disorders, other personality disorders, and a range of medical disorders.(5) Patients with BPD generally experience high levels of dysphoria and psychic pain (6), usually in the context of interpersonal distress. Some patients electively seek help from a psychiatrist or primary care physician, and they complain of anxiety, depression, or suicidality. Others, feeling distressed by real or perceived

maltreatment or rejection by others, may attempt suicide or behave in other self-injurious ways, leading to emergency intervention. Careful history taking often reveals a pattern of emotional and behavioral dysregulation prior to initiation of treatment, not uncommonly accompanied by a history of trauma, abuse, or neglect early in life.(1)

“Recurrent suicidal behavior, gestures, or threats or self-mutilating behavior” is one of the DSM-IV-TR diagnostic criteria for BPD, and self-injurious behavior has been referred to as the borderline patient’s “behavioral specialty.”(7) Deliberate self-harm includes suicide attempts (intentionally self-destructive acts accompanied by at least a partial intent to die) and non-suicidal self-harm (intentional self-destructive behavior with no intent to die).(8) It is estimated that as many as 75% of patients with BPD make at least one non-lethal suicide attempt (8), and the rate of actual suicide in patients with BPD is between 8% and 10%.(9,10) Risk factors for suicidal behavior in patients with BPD include prior suicide attempts, family history of suicidal behavior, history of sexual abuse, high levels of hopelessness, co-morbid mood disorders and substance use disorders, and high levels of impulsivity and/or antisocial traits.(9)

The American Psychiatric Association Practice Guideline for the Treatment of Patients with Borderline Personality Disorder (5) provides an evidence-based recommendation for psychotherapy as the primary, or core, treatment of patients with BPD, accompanied by symptom-targeted adjunctive pharmacotherapy. In most cases, the psychotherapy, whether cognitive-behavioral or psychodynamic, is carried out in an outpatient or partial hospital setting and involves weekly treatment for a year or more. The priority treatment goal that characterizes the early phase of psychotherapy is to help the patient learn to reduce self-harming and suicidal behavior. A common error in treatment of patients with BPD is to underestimate the importance of self-injurious behavior or to view suicidal ideation as only likely to lead to non-lethal suicide “gestures.” The largely heritable endophenotypes that underlie this behavior are thought to be impulsive aggression and affect dysregulation (11), and it is often interpersonal stress that precipitates affect-laden, impulsive self-harming behavior.

In the case presented here, the patient had known risk factors of former suicide attempts and self-inflicted trauma. It is not clear what precipitated the unsuccessful suicide attempt that led to the current hospitalization, but clarifying the interpersonal circumstances that were occurring in her life prior to the suicide attempt would be crucial. Patients with BPD frequently demonstrate mood shifts, and this patient, in the structured setting of the hospital, shed her dysphoria and requested a home visit for her birthday. Who was at home? What was the nature of the patient’s relationships with those at home? What have previous birthday celebrations been like? Since family stress and interpersonal conflicts are so common for patients with BPD, birthdays are often formulas for disappointment. In this case, perhaps all signals were green and the self-injury on the home visit could not have been anticipated. However, given the modal pattern of disturbed family and interpersonal relationships for patients with BPD, it seems far more likely that the patient’s expectation of a positive home visit on her birthday represented an idealized fantasy. Patients with BPD can become angry and oppositional when challenged, and the staff may have supported the patient’s request partially, at least, to prevent a regressive eruption of rage and the possibility of reactivated self-injurious behavior in the hospital.

Clinicians often feel conflicted about management decisions such as this one when working with patients with BPD. There is controversy about the role of the hospital, particularly regarding its therapeutic

usefulness for self-injurious behavior in borderline patients.(12) However, hospitalization may be essential at times of extreme suicide risk, such as that in the case presented here. Evaluation tools to assess degree of suicide risk, such as the Suicide Behaviors Questionnaire (revised) (13) or the Suicidal Ideation and Risk Level Assessment (14), are generally applicable for patients with major depressive disorder or bipolar disorder, and these may be useful to guide treatment of patients with BPD who have this type of Axis I comorbidity. However, when the suicide attempt occurs impulsively as a function of BPD itself, it may be difficult to predict. As in the case here, careful evaluation of potential interpersonal stress during times of re-exposure to environments in which suicidal behavior has previously occurred may be helpful. General guidance can be obtained from the American Psychiatric Association Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors.(15)

Take-Home Points

This case illustrates the following strategies when treating patients with BPD:

- Patients with BPD have significantly elevated risk of suicide, and suicide attempts and self-injurious behavior must be taken seriously, including the use of brief hospitalization when necessary.
- Interpersonal and family relationships in patients with BPD are characterized by turbulence and intense swings from idealization to devaluation, and the reverse.
- Active communication among all clinicians participating in the treatment of a patient with BPD is essential. Hospital staff should make every effort to consult with the referring therapist and, preferably, to schedule joint meetings during the patient's inpatient stay.
- Similarly, active communication with the patient's family and significant other persons in the patient's current life should be pursued.

John M. Oldham, MD Professor and Chairman, Department of Psychiatry & Behavioral Sciences Executive Director, Institute of Psychiatry Medical University of South Carolina

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Table

Diagnostic Criteria for Borderline Personality

*Reprinted with permission from the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, (Copyright 2000). American Psychiatric Association. (2)

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts as indicated by five (or more) of the following:

1. Frantic efforts to avoid real or imagined abandonment. Note: do not include suicidal or self-mutilating behavior covered in Criterion 5.

2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.

3. Identity disturbance: markedly and persistently unstable self-image or sense of self.

4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). Note: do not include suicidal or self-mutilating behavior covered in Criterion 5.

5. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior.

6. 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).

7. Chronic feelings of emptiness.

8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).

9. Transient, stress-related paranoid ideation or severe dissociative symptoms.

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