A 44-Year-Old Woman With Borderline Personality Disorder

John M. Oldham, MD, Discussant

DR BURNS: Ms J is a 44-year-old woman with a history of borderline personality disorder. She lives alone and currently works full-time as a residential counselor in the mental health field. She purchases Medicaid-type insurance through Common Health in Massachusetts. She initially came to see Dr M in July 2000 because she was unhappy with her previous primary care physician.

Ms J has an extensive psychiatric and comorbid medical history. She first had contact with a mental health care professional at the age of 22 after moving away from home and starting her first job. The transition precipitated extreme anxiety, and Ms J lost her sense of self-direction. She became extremely dependent on others and feared abandonment. When other changes and personal losses occurred, Ms J reacted with intense emotional instability, marked by depression and intermittent anger. She has had numerous, prolonged hospitalizations for depression, suicidal ideation, and suicidal behavior with multiple drug overdoses and self-injury. These factors led to the diagnosis of borderline personality disorder. Additionally, Ms J has many medical problems that have necessitated additional hospitalizations, surgery, and orthopedic interventions. Some physicians have questioned whether these medical problems had a psychological component to them.

Ms J has been in outpatient treatment with various health care providers since about 1978. She has had multiple psychiatric and medical inpatient hospitalizations. Over the years she also has participated in day treatment programs, residential treatment, and a supportive housing program that helps individuals access housing and live independently. Ms J has participated in several dialectical behavior therapy (DBT) skills training groups.

Her medical history is significant for arthritis following a motor vehicle collision, chronic back pain, seizure disorder, sleep apnea for which she receives continuous positive airway pressure, nocturnal myoclonus, migraine headaches, hyperlipidemia, and gastroesophageal reflux disease. Ms J has a history of asthma and psychogenic laryngospasm that required tracheostomy placement for 4 months in 1999. She had a hysterectomy in 1996. She cannot tolerate hormone replacement therapy due to worsening depression.

Despite this history, Ms J has made tremendous strides in the past 4 years. Five years ago, she was hospitalized for 265 days in 1 year; however, during 2001 she was hospitalized for only 4 days. In the past, she has taken lamotrigine, nortriptyline, desipramine, imipramine, fluoxetine, sertraline, paroxetine, citalopram, nefazodone, venlafaxine, tranylcypromine, isocarboxazid, phenelzine, quetiapine, olanzapine, risperidone, and lithium. Her current psychiatric medications are sustained-release bupropion, 150 mg/d; topiramate, 100 mg twice daily; and amitriptyline, 10 mg at bedtime. She is no longer taking clonazepam after 20 years of use. Her medical regimen includes albuterol, fexofenadine, fluticasone, omeprazole, montelukast, carbamazepine, tramadol, zolmitriptan, verapamil, and rofecoxib. Both she and the nurse specialist who provides her medications are now comfortable with her having a 1-month supply of medications, along with refills.

Ms J attributes her improvement to a good working relationship with her current therapist, a clinical social worker, and a DBT program. She has a close relationship with her parents and all but one of her sisters. She also has established close and supportive friendships.

There is no family history of mental illness in first-degree relatives. Her parents are in their 70s. She does not smoke or drink alcohol. She reports being allergic to penicillin, erythromycin, phenytoin, acetaminophen/oxycodone hydrochloride, sertraline, tetracycline, intravenous pyelogram dye, novocaine, haloperidol, sulfa-containing medications, and diazepam.

Ms J wonders what her future will bring, whether she can maintain her progress, and what could help her be successful in the long run.

MS J: HER VIEWS

I first started having mental health problems around 1980, when I first got out of college. I had moved away from home. I was in my first apartment and it was a really big change.

This conference took place at the Combined Longwood Psychiatry Grand Rounds of the Massachusetts Mental Health Center, the Beth Israel Deaconess Medical Center, and the Brigham and Women's Hospital, Boston, Mass, and was held at Beth Israel Deaconess Medical Center on September 25, 2001.
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And all of a sudden I just felt like my life was a whirlwind and I couldn't be like everybody else. I became really anxious, and I began to see a therapist for the first time. I began to spill out everything that I was feeling. As I look back at it now, I let her tell me how I was feeling, and I took those feelings in. And every feeling I had they would try to medicate. I feel this, boom, medicate it; I feel that, boom, medicate it. From then on, it was a long road of a lot of hospitalizations and many therapists.

I have tried to hurt myself [a few] times. Two that I remember have been when very significant caregivers have moved on, and I took it personally. I thought that it was because of me that they left. Another was when my grandmother died—she was a very important person in my life.

When someone mentioned borderline personality, I thought "I don't have different personalities." Why label someone with a borderline personality and then not explain to them what borderline personality is? Borderline personality is so hard to explain. It mostly means that I can do things just as much as anybody else can, but that it's a little bit harder. It mostly means that I may depend on someone more than I should.

I heard somebody say not too long ago, which totally flipped me out, that people with borderline disorder do not have a tendency to move on in life into a career. I was furious. You have to have specialists tell the residents, don't tell that kind of crap to your patients. Never tell someone there's not a chance they'll move on. Yeah, they can be dependent, but they can move on with life.

DR *M*: HER VIEWS

Ms J has been carrying the diagnosis of borderline personality disorder for many years. Over the course of the time that I've known her, she has been doing dramatically better, according to her and her therapist.

Over the last 10 months, she was in the hospital for one very short stay. It's been a tremendous success keeping her out. She's not had any suicide attempts. She's not had any overdoses. She's had very few of the medical problems that seem intertwined with her borderline personality disorder.

I would like to know the actual prevalence of borderline personality disorder because I wonder if many people who have it go undiagnosed. I am interested in knowing the typical natural course for a mild to moderate case and whether there's any need for intervention, including diagnosis and labeling. For Ms J in particular, I'm interested in how to make her feel like we're caring for her in the setting of her multitude of medical and orthopedic illnesses while maintaining her psychiatric improvement. Is the dramatic improvement that she has shown over the past year or 2 related to certain therapies for her borderline personality disorder? What could happen to send her backward? And how can I as a medical provider help her therapist prevent her from relapsing?

AT THE CROSSROADS: QUESTIONS FOR DR OLDHAM

What is borderline personality disorder? What is the prevalence, age of onset, and natural history? How is the diagnosis established? When should primary care physicians consider this diagnosis in their patients? What comorbidities are common? How effective are behavioral and other therapeutic interventions? How effective are psychotropic medications? How should the primary care physician and mental health professional best collaborate in providing care to these patients? How do you discuss this diagnosis with patients? Can patients with borderline personality get better? What do you recommend for Ms J?

DR OLDHAM: Ms J is a 44-year-old woman diagnosed as having borderline personality disorder along with multiple comorbid medical conditions. The patient's illness began in her early 20s, when she developed significant anxiety after moving away from home for the first time. She began treatment and soon became inordinately dependent on her therapist. "I let her tell me how I was feeling," Ms J reported, and she lost any sense of self-directedness. Depression figures prominently in her history, with periodic hospitalizations for suicidal behavior, each time after loss of a therapist or other significant figure in her life (she reported, "I took it personally . . . that it was because of me that they left"). It is not clear whether her depressive symptoms are components of her borderline personality disorder or if they reflect a comorbid depressive disorder. She denies any history of neglect or abuse or of psychiatric illness in her family. She has received extensive treatment for her nonpsychiatric medical conditions, for which she has also required hospitalization. Her medical history reveals a cornucopia of medication trials, and her current regimen consists of more than a dozen medications to regulate her mood, control her seizure disorder, and treat her chronic pain, asthma, migraines, and other medical conditions. In the course of this patient's extensive contacts with medical providers, inevitable questions have been raised about the independent validity of her many diagnoses, and at times some of her symptoms have been seen as "psychosomatic." Despite years of severe disability, however, Ms J's condition has improved and she is currently employed, functioning with a substantial degree of independence, and optimistic about her future.

Diagnosis, Etiology, Epidemiology, and Comorbidity

The current edition of the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (*DSM-IV*)[1] stipulates that, for any personality disorder to be diagnosed, significant emotional distress, impairment in social or occupational functioning, or both must be present. Personality disorders must be of early onset, enduring over time and across situations, and not solely a product of a general medical condition, medication, or abused substance. Borderline personality disorder is categorized in the dramatic/emotional/erratic/impulsive cluster of personality disorders; diagnosis is made when at least

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5 of 9 criteria are met.[1] Although there is substantial heterogeneity among patients with borderline personality disorder, good interrater diagnostic reliability has been reported.[2,3] The prototypic patient with borderline personality disorder shows a pervasive pattern of instability of mood, impulse control, interpersonal relationships, and self-image.[4] The *DSM-IV* criteria for the diagnosis of borderline personality disorder are shown in **Box 1**. Ms J's clinical history reveals the presence of at least 5 of these criteria. Criterion 1 (efforts to avoid real or imagined abandonment) is demonstrated by Ms J's pattern of strong dependency on others, a tendency she described as "latching on" to others and resisting any change in her relationships. Her interpersonal relationships were intense and unstable (criterion 2), reflected by neediness, frequent crises, and eventual disappointment in others. This pattern was apparent in her treatment as well; she sought relief for distressing emotions such as anxiety and depression, and after taking prescribed medications, she complained that she "never felt anything" and that "every feeling I began to feel they would try to medicate." She lacked autonomy and a sense of her own identity (criterion 3). "I didn't know what to do with myself," she said, adding that she felt "overwhelmed" by the challenges involved in living on her own. Ms J was recurrently suicidal (criterion 5), and she experienced strong periods of moodiness, depression, anxiety, and irritability (criterion 6) in reaction to environmental or interpersonal stress or loss.

The age at onset of borderline personality disorder can range from adolescence to adulthood but usually occurs between 18 and 25 years.[5] Patients with borderline personality disorder 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. Diagnosis of borderline personality disorder may be made at the first episode of treatment, but more often the diagnosis only becomes apparent over time, and the initial diagnosis reflects the presenting symptoms, eg, an anxiety, depressive, or substance use disorder. 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.[5]

The *DSM-IV* uses an atheoretical approach to diagnosis, relying on published studies and clinical reports to guide the development and periodic revision of the diagnostic criteria for each disorder. In addition to this symptom-based, descriptive approach, borderline personality disorder can be conceptualized along theoretical lines. Subtypes of borderline personality disorder may be derived from different (non–mutually exclusive) theories of its etiology,[7] an example of which is as follows.

Type 1. Affective: an atypical, moderately heritable form of mood disorder. Akiskal[8] described a "subaffective" disorder, and Klein and Liebowitz[9] described a condition called "hysteroid dysphoria," both of which resemble a form of borderline personality disorder characterized by the predominance of affect dysregulation. Patients with this type typically experience intense anxiety or depression, often accompanied by suicidal gestures, in response to interpersonal stress.

Type 2. Impulsive: a form of impulse control disorder, reflecting an action-oriented inborn temperament. A number of reports have characterized borderline personality disorder as an impulse-spectrum disorder, sharing a propensity to action, and overlapping with other disorders of impulse control such as substance use disorders and antisocial personality disorder.[5,10-12] Such patients may engage in impulsive self-injurious behavior, such as cutting or burning themselves, or they may be impulsively self-destructive in other ways such as use of substances, binge eating, or reckless driving.

Type 3. Aggressive: a primary constitutional temperament[13] or a secondary reaction to early trauma, abuse, or neglect.[14] Such a predominance of aggression in borderline personality disorder could be correlated with reduced central nervous system serotonin levels or other neurotrans-

Box 1. *DSM-IV* Diagnostic Criteria for Borderline Personality Disorder*

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 ≥5 of the following:

1. Frantic efforts to avoid real or imagined abandonment (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 2 areas that are potentially self-damaging (eg, spending, sexual behavior, substance abuse, reckless driving, binge eating) (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 (eg, 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 (eg, frequent displays of temper, constant anger, recurrent physical fights)
9. Transient, stress-related paranoid ideation or severe dissociative symptoms

**DSM-IV* indicates *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition.* Criteria reproduced with permission.[1]

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mitter or neuroendocrine irregularities.[11] Patients with this type may frequently become intensely and inappropriately angry or irritable.

Type 4. Dependent: an intolerance of being alone. Masterson and colleagues[15,16] proposed that, in some cases, the presence of parental intolerance of the development of autonomy in the child could lay the foundation for future borderline pathology. Gunderson[17] described a similar but somewhat broader concept, the intolerance of being alone, as a common defining characteristic of many patients with borderline personality disorder. Such patients may be overly compliant or even clinging in relationships, constantly fearing abandonment.

Type 5. Empty: lack of a stable sense of self, reflecting inconstant early parenting. Adler and colleagues[18,19] proposed that the experience by the preborderline child of parental inconstancy and lack of empathy could interfere with the establishment of basic trust, resulting in an inability to evoke soothing memories of good, nurturing early caretakers. Patients with this type lack a "centered" sense of self, and they describe a feeling of inner emptiness and lack of independent goal-directedness.

These theoretical subtypes of borderline personality disorder might differ in their predominant symptoms, with different prototypic criteria. In the case of Ms J, predominant symptoms include mood instability characterized by depressive episodes precipitated by environmental circumstances, particularly related to an intolerance of interpersonal loss, and the lack of an autonomous sense of self. Hence, using the above typology, Ms J demonstrates a combination of types 1, 4, and 5, reflecting her mood reactivity and suicidality (type 1), her dependency and fear of abandonment (type 4), and her lack of self-directedness and sense of self (type 5), as described previously.

Borderline personality disorder is estimated to occur in approximately 2% of the population in community samples,[4,20,21] in 6% in a primary care population,[22] and in about 15% to 20% of psychiatric inpatients.[4,21] It can range in severity from moderately disabling to severely incapacitating.[23,24] Comorbidity is common, including comorbid *DSM-IV* Axis I conditions such as mood disorders, anxiety disorders, eating disorders, and substance use disorders; comorbid Axis II disorders (co-occurring personality disorders); and comorbid medical disorders.[4,25]

Natural History and Course

Patients with borderline personality disorder often have a stormy course, punctuated with episodes of high-risk behavior. The course for an individual patient will be influenced by the patient's symptom profile as well as the presence of comorbid conditions. Due to the disabling nature of the disorder, accompanied by high levels of emotional pain and distress, patients generally seek treatment, and longitudinal[26] and controlled[4] studies make a persuasive case that treatment is beneficial. Negative prognostic factors include high levels of psychopathy (antisocial behavior) and comorbid substance abuse.[27] A common misapprehension by family, friends, and often by clinicians is that patients with borderline personality disorder are not likely to commit suicide since suicidal behavior is seen as a bid for attention, misjudged as not serious. In fact, roughly 8% to 10% of patients with borderline personality disorder do commit suicide, a prevalence more than 400 times higher than in the general population.[5]

If patients with borderline personality disorder adhere to treatment and overcome high-risk behavior, they may ultimately do quite well. Several major longitudinal studies of borderline personality disorder have been conducted and all indicate that over time, most patients with borderline personality disorder show substantial improvement.[27-30] In general, positive prognostic factors include high intelligence, lack of early abuse, low levels of psychopathy, and lack of comorbid substance abuse.[31] As described in the section on treatment below, and in the recently published practice guideline developed by the American Psychiatric Association (APA),[4] there is consensus that psychotherapy helps, augmented by symptom-targeted pharmacotherapy. Other factors that may contribute to improvement include exposure to other types of healing relationships and the reduction of impulsivity that apparently occurs as patients grow older.[32]

Diagnosis in a Primary Care Setting

It has been suggested that the primary care or family practice physician is the most likely professional to encounter patients with borderline personality disorder.[33] Although borderline personality disorder is diagnosed when a patient has at least 5 of the 9 *DSM-IV* criteria for the disorder, in a primary care setting it may be difficult to make this determination. Some patients may present with chief complaints of depression and anxiety, and the differential diagnosis should include major depressive disorder, dysthymic disorder, bipolar II disorder, posttraumatic stress disorder, bulimia, and substance use disorder.[5] In cases in which depressive symptoms are prominent, the clinician should be alert to recurrent patterns of extremely strong reactions to interpersonal stress, particularly the loss of a relationship, or real or perceived disloyalty or betrayal. Patients with borderline personality disorder will react to such real or imagined losses with depressive symptoms, sometimes accompanied by suicidal ideation or behavior, substance use, or other reactions, but they will not develop a sustained vegetative depressive state.[7] In other cases, patients may demonstrate volatile, impulsive, angry, or self-destructive patterns of behavior that can have the appearance of being manipulative and guilt-inducing, but in fact reflect intense anxiety and distress. In a primary care setting, it may be difficult in a brief office visit to obtain such detailed or longitudinal information from the patient, and significant underdiagnosis of this disorder may occur.[22] Collateral history from a family member or other informant, if available, can be helpful.

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Borderline personality disorder has been associated with somatization disorder[34]; somatic preoccupation[35]; medically self-harming behavior such as making medical situations worse or abuse of prescription medication[36]; increased physician visits, telephone contacts, and number of prescriptions written[37]; and generally higher utilization of primary care resources.[38] Although some physical and laboratory abnormalities have been reported in patients with borderline personality disorder, such as increased left-sided neurological "soft" signs,[39] neuroendocrine abnormalities,[11,40-44] rapid eye movement sleep abnormalities,[45] and brain imaging abnormalities,[46-50] these findings remain somewhat controversial and of unclear clinical significance. In some cases, the dysphoria of the patient with borderline personality disorder can take the form of physical symptoms, such as headache, chronic fatigue syndrome, nausea and vomiting,[51] or other gastrointestinal symptoms accompanied by laxative abuse.[36] When such patients are followed up in a primary care setting, it is important to thoroughly rule out any comorbid medical disorders. Careful history taking and physical examination are the best guides regarding the extent of a medical and laboratory workup to carry out in patients with borderline personality disorder who present with physical complaints. Management of the patient is greatly enhanced if the primary care physician understands that the patient's symptoms are real and distressing to the patient and that they are not deliberately induced or fabricated, even if precipitated by emotional events such as interpersonal loss or disappointment. Such an approach, validating rather than challenging the distressed and symptom-ridden world of the patient, helps the patient feel understood. Referral to a psychiatrist may then be successful in the context of obtaining help for the cumulative stress experienced by the patient; the patient should be followed up jointly by primary care and psychiatry, as indicated, rather than immediately transferred to a psychiatrist for ongoing care and disenrolled from the medical clinic.

The usefulness of psychoeducational approaches to explain the diagnosis to the patient and family has been increasingly advocated.[5] Generally, an explanation that the condition is called "borderline" because it is a problem in mood or impulse regulation that is "on the border" of other conditions such as depressive, anxiety, or substance use disorders can be quite helpful.

Treatment of Borderline Personality Disorder

The APA practice guideline[4] recommends psychotherapy as the primary treatment for borderline personality disorder, along with symptom-targeted adjunctive pharmacotherapy. These recommendations are made with "substantial clinical confidence," based on published randomized controlled trials of both psychotherapy and pharmacotherapy, as well as clinical consensus. Although the APA does not specifically endorse a particular form of psychotherapy for borderline personality disorder, 2 types have been shown to be effective in randomized controlled trials: a particular type of cognitive behavioral therapy known as dialectical behavior therapy (DBT)[52-56] and psychodynamic psychotherapy.[57,58] Dialectical behavior therapy implies an ongoing tension, or dialectic, between validation and what might be called compassionate admonition. For example, patients with borderline personality disorder often have histories of trauma and abuse, and the therapist attempts to convey understanding of the historical validity of the patient's mistrust of others. At the same time, the therapist's task is to help the patient learn to expect and elicit constructive responses from others and to take responsibility for his or her behavior in the present. Linehan and colleagues[53] conducted a randomized trial and found that at the end of 1 year of treatment, the presence of parasuicidal (self-injurious) behavior decreased from 100% to 64% in the 20 borderline patients receiving DBT compared with a decrease from 100% to 96% in the 21 borderline patients who received usual treatment. In addition, those receiving DBT showed less treatment dropout and fewer psychiatric hospital days and admissions.[53] In a randomized study of a second cohort of borderline patients, Linehan et al[56] reported that compared with controls, patients receiving 1 year of DBT showed reduced anger (effect size, 0.81), improved scores on the Global Assessment Scale (effect size, 0.79), and superior interviewer ratings on global social adjustment (effect size, 0.68).

In contrast to DBT, psychodynamic psychotherapy generally involves exploring patterns of feelings and motivated behavior, attempting to clarify aspects of these feelings and behaviors that are not initially consciously available to the patient. In a randomized controlled trial of this type of therapy in patients with borderline personality disorder, provided in a partial hospital setting, Bateman and Fonagy[57] found reduced self-injurious behavior, anxiety, and depression compared with patients receiving general psychiatric care. In both of these approaches, the therapy was provided as a combination of weekly individual psychotherapy sessions, along with separate group sessions (eg, designed as group "skills training" in DBT). A review of the published literature on psychotherapy for personality disorders clearly indicates that it is effective for borderline personality disorder.[59] It is reassuring that similar conclusions are emerging based on systematic studies using carefully designed methods.[4] Most psychotherapy approaches used for borderline personality disorder have a number of factors in common, summarized in BOX 2.

In addition to psychotherapy, symptom-targeted pharmacotherapy is recommended. Soloff[60] reviewed the published literature on psychopharmacological treatment of borderline personality disorder, including randomized placebo-controlled double-blind trials, open-label studies, and case reports, and this material is presented in detail in the APA practice guideline.[4] Generally, for an individual patient, a sequence of medications can be developed depending on the broad category of the patient's predominant symptoms (cognitive-perceptual symptoms, affective dysregulation, or impulsive-behavioral dyscontrol). In general, low-dose antipsychotics (eg, haloperidol, olanzapine, risperidone) are indicated for cognitive-perceptual symp-

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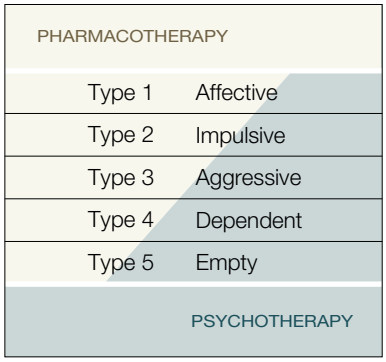
Box 2. Common Features of Recommended Psychotherapy for Borderline Personality Disorder*

Therapy is not expected to be brief
A strong helping relationship develops between patient and therapist
Clear roles and responsibilities of patient and therapist are established
Therapist is active and directive, not a passive listener
Patient and therapist mutually develop a hierarchy of priorities
Therapist conveys empathic validation plus the need for patient to control his/her behavior
Flexibility is needed as new circumstances, including stresses, develop
Limit setting, preferably mutually agreed upon, is used
Concomitant individual and group approaches are used

*Adapted with permission from American Psychiatric Publishing Inc.[7]

Figure. Balance of Combined Treatment According to Type of Borderline Personality Disorder



For each type of borderline personality disorder, a combination of psychotherapy and pharmacotherapy is indicated. Reliance on pharmacotherapy will be greater, particularly early in the course of treatment, for types 1-3 until affect regulation and impulse control have stabilized. Adapted with permission from American Psychiatric Publishing Inc.[7]

toms, such as paranoid ideation or hallucination-like states, and selective serotonin reuptake inhibitors (eg, fluoxetine, sertraline) are indicated to stabilize affective dysregulation such as mood lability or inappropriate intense anger and to stabilize impulsive-behavioral dyscontrol such as self-mutilation or self-damaging binge behavior (eg, substance abuse).[4,60] Tricyclic antidepressants are generally not recommended for patients with borderline personality disorder.[61] Algorithms have been developed based on the published literature[4] that can help the clinician and the patient make thoughtful decisions about potentially helpful medications.

Both psychotherapy and symptom-targeted pharmacotherapy should be planned in an overall context of psychiatric management[4] that includes clear identification of the patient's primary therapist, expected roles and responsibilities of patient and therapist, a plan for responding to crises and monitoring for patient safety, and coordination of treatment among multiple clinicians involved in the patient's care.

Recommendations for Ms J

Ms J describes a long history of therapy, some of which has been helpful and some not. Although it is unfortunate that there have been components of her treatment experience that, in retrospect, Ms J views as unhelpful, combined with multiple extended hospitalizations, such patterns are not uncommon for patients with borderline personality disorder. Regular communication among all treating health care professionals is of particular importance in this condition, and setbacks are not unusual, eg, when treatment is provided in a teaching setting that requires a relatively frequent change of therapists. Interestingly, Ms J reports that too often her therapists have been quick to "medicate every feeling" as a core strategy, rather than rely on sustained psychotherapy as the primary approach. In this sense, Ms J's insights mirror the recommendations of the APA borderline personality disorder practice guideline,[4] which recommends psychotherapy as the primary treatment approach, combined with adjunctive pharmacotherapy. The relative balance of psychotherapy and pharmacotherapy may differ from one patient to the next; the FIGURE illustrates such differences, using the theoretical typology described earlier. Ms J emphasizes that DBT has been most beneficial for her, and this information is important. The inherent oscillation in DBT between validation of (and empathy for) the suffering and worldview of the patient (based on the patient's particular temperament and life experiences) and the need to help the patient learn to change and control her behavior, to reduce self-destructiveness and increase interpersonal effectiveness, has been experienced by Ms J as helpful. In the extended interview, she said, "I finally got a therapist who got me into a DBT group. . . . It was awesome. I was so excited to learn that there are different ways to do different things; that I had to learn to say no. I had to learn to do things that were best for myself."

There is no absolute formula for how long DBT itself or psychotherapy and pharmacotherapy should be maintained. Linehan[52] and Koerner and Linehan[62] describe a treatment approach conceptualized in stages that can occur over many years, but the emphasis during the first stage of DBT, which lasts about 1 year, is on achieving behavioral control. During this stage of DBT, a hierarchy of treatment targets is prioritized, starting with efforts to reduce life-threatening or self-injurious behaviors, followed by efforts to reduce behaviors that interfere with adherence to treatment. As the patient's clinical condition begins to stabilize and evidence of improved emotional regulation emerges, the focus of therapy then broadens to include work on increasing behavioral skills and reducing behaviors that interfere with quality of life.

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Ms J has a number of positive prognostic factors, including good premorbid functioning, high intelligence and educational achievement, lack of a comorbid problem of substance abuse, and absence of a history of trauma and abuse early in her life. Even though she has had many turbulent years of significant disability, she has participated persistently in treatment and has reached a stage in her life in which she shows high motivation to minimize or eradicate the need for further hospitalizations and to succeed socially and vocationally. The effectiveness of DBT in her case should be noted, as she herself emphasizes, and ongoing treatment should rely primarily on psychotherapy based on DBT principles and techniques. Adjunctive pharmacotherapy may continue to be periodically helpful, but it should be a secondary component of the treatment. If, however, Axis I comorbidity is present, eg, major depressive disorder, comprehensive care should include appropriate treatment of the coexisting pathology. In addition, ongoing medication management for Ms J's coexisting medical conditions such as asthma and seizure disorder should be sustained, with careful attention to adverse effects and any potential drug-drug interactions. Careful and frequent communication among psychiatric and nonpsychiatric clinicians will be critical to the continued success of her treatment because patients with borderline personality disorder remain sensitive to stress, particularly of an interpersonal nature, and such stress can precipitate episodes of emotional dysregulation as well as exacerbations of her coexisting medical conditions.

Goals of treatment should be frequently reexamined and developed and revised mutually between Ms J and her psychotherapist. Linehan[52] recommends generating with the patient a list of possible goals for a particular problem and then ranking them in order of desirability. In the case of Ms J, for example, a goal to set limits on a specified behavior, such as between-session telephone calls to the therapist, should be understood as one of many steps toward greater autonomy and self-sufficiency, and limit-setting of this sort should be mutually agreed upon and given a high priority among multiple goals. Such a plan should be designed together and can be incorporated into other monitoring devices such as the use of a calendar, with clear notations or flags indicating periods of success in achieving this goal, among others. From the perspective of long-term goals, it is important to help the patient understand that getting better does not mean being abandoned. Any future decision to substantially reduce the intensity or frequency of psychotherapy, or to consider psychotherapy "holidays" or a "trial graduation" (which can be helpful strategies, in my experience), should be made only when the patient herself feels motivated to take such a step and she and the therapist agree that the patient is ready to do so.

QUESTIONS AND DISCUSSION

A PHYSICIAN: In practicing general medicine these days, we are trying to share decision making with our patients. We are using the medical record more as a convener between the clinician and the patient. How do you do this with a patient who has borderline personality disorder? How do you explain the diagnosis and what kind of information do you share with these patients?

DR OLDHAM: I think that educating patients is extremely important. Gunderson[5] has written about psychoeducation and the need to talk directly to the patient, as well as the patient's family, specifically and explicitly about this disorder. Many clinicians review the *DSM-IV* criteria for borderline personality disorder with patients and families to help them understand the diagnosis. In talking to patients and families, I think it is helpful to say that we call this condition "borderline" because it borders on other psychiatric conditions that share certain symptoms, such as impulsive behavior or extreme mood states. I think the medical record should include these concepts in language that the patient can see and understand.

A PHYSICIAN: If the primary treatment approach for this disorder is psychotherapy, isn't it time to move from labels to really trying to understand the underlying dynamics of these disorders and making our diagnoses and treatment based on that?

DR OLDHAM: I absolutely agree that whatever therapeutic approach you take needs to be psychodynamically informed. It is within that level of understanding that one tries to work with the individual patient. In addition, this is a very exciting time in psychiatry because we are learning more about the value of psychotherapy as a primary treatment, and we are moving closer to understanding its mechanism of action. Kandel has been an eloquent and prescient spokesman on the topic; in 1979 he wrote a paper in which he predicted that, to the extent that psychotherapy works, it does so by changing the cellular architecture of the brain.[63] He later elaborated on that notion, describing the probable gene activation and protein synthesis involved in cellular growth produced by psychotherapy.[64] We have some preliminary evidence that antidepressants and even electroconvulsive therapy involve neurogenesis, and the possibility that psychotherapy may also have this effect is intriguing to consider.[65,66] So I think it's interesting to expand our thinking about psychotherapy as an active, effective biological treatment.

A PHYSICIAN: Could you offer some practical recommendations to internists about the boundaries of what they can effectively do with their patients who have this disorder and when they should refer patients to a psychiatrist or psychotherapist?

DR OLDHAM: It is appropriate to refer when patients engage in repeated self-injurious or life-endangering behaviors, or when their needs for reassurance or safety monitoring involve many interappointment contacts.

A PHYSICIAN: How do you manage medical problems in patients like Ms J, and how do you determine what, if any, laboratory evaluation is indicated?

DR OLDMAN: Ms J has multiple symptoms in both the psychiatric and medical realms. The literature offers little guidance in this area, other than carefully tracking the pre-

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senting symptoms of the patient and exploring any plausible coexisting medical conditions. Some literature indicates that if a patient has borderline personality disorder along with comorbid medical conditions, those conditions may be more severe and less responsive to treatment.[37,67] I think what needs to happen is communication of basic information about borderline personality disorder within the general medical field so that there can be early recognition of the disorder and appropriate psychiatric consultation or referral. Joint medical and psychiatric treatment is usually best for patients with borderline personality disorder and comorbid medical conditions, and coordination among treatment providers is extremely important.

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CLINICAL CROSSROADS

UPDATE

A 45-Year-Old Woman With Obsessive-Compulsive Disorder, 1 Year Later

At Psychiatry Grand Rounds in October 2000, Michael A. Jenike, MD, discussed a 45-year-old woman with obsessive-compulsive disorder (OCD).[1] Mrs T described symptoms of OCD dating back to childhood. In her 20s she was hospitalized for depression, but no one diagnosed her OCD. In her 30s she recognized her own diagnosis while watching a television show about OCD. Subsequently, Mrs T benefited greatly from cognitive behavior therapy and medications. However, she had major difficulty tapering the use of paroxetine (75 mg/d), with fever, aches, and shaking for months. At the time of the conference, she was beginning to feel anxious and wondered if she needed to restart the medication.

Dr Jenike defined OCD and explained its relationship to depression and posttraumatic stress disorder. He described what is known about the genetic susceptibility and pathophysiology of OCD and explained the utilities and limitations of both cognitive behavior therapy and medications. Finally, he discussed when neurosurgery might be appropriate. He surmised that Mrs T would need to practice cognitive behavior therapy indefinitely and would probably need to restart medication at some time in the future.

MRS T, THE PATIENT

Two days after the Clinical Crossroads Grand Rounds, I went back on Luvox [fluvoxamine maleate], 50 mg/d. This stopped the racing thoughts and I had no side effects. Nevertheless, I continued to suffer from major depression and ended up being admitted to the hospital for 2 weeks of intensive inpatient therapy. I returned home and continued working with my therapist 1 to 2 times a week. I then entered a period of severe insomnia that did not respond to high doses of [benzodiazepines], and I ended up in the hospital again. My OCD symptoms began to resurface under the intense lack of sleep and stress and agitation from that. After a 2-week hospitalization, I was well enough to return home, just a few days ago. Recently, I started to participate in a women's support group for OCD that has really helped me get out of my house and combat isolation. I am now using my OCD relapse prevention skills and relaxation techniques and seeing my therapist regularly.

Other than speaking to others with OCD looking for advice and help on getting treatment, I rarely even think about the OCD rituals I used to do. I continue to feel so blessed to have such wonderful help and support from my family, my professional team, and my faith, all of which keep me working very hard to stay well.

Richard A. Parker, MD
Erin E. Hartman, MS

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