Prevention and early intervention for borderline personality disorder

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ABSTRACT

- Borderline personality disorder (BPD) is a severe mental disorder that is associated with substantial psychosocial impairment and morbidity, disproportionate use of health resources, a high suicide rate, and a reputation for being "untreatable".
- A diagnosis of BPD in young people has similar reliability, validity and prevalence to BPD in adults, and almost certainly has serious and pervasive negative repercussions over subsequent decades.
- Current data are inadequate to inform specific *universal* or *selective* prevention programs for BPD. However, they do support including BPD prevention as an outcome when evaluating universal and/or selective interventions for a variety of mental health problems and adverse psychosocial outcomes.
- The strongest data support *early intervention* for the emerging BPD phenotype. Early intervention programs will need to be realistic in their aims, require change in clinician attitudes and service systems, and must be mindful of the risk of iatrogenic harm.

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Borderline personality disorder (BPD) is a severe mental disorder, characterised by a pervasive pattern of instability in affect regulation, impulse control, interpersonal relationships, and self-image[1] (Box). BPD affects about 1.4% of the general population,[2] but it is the most common and the most serious of the personality disorders (PDs) in clinical practice, affecting up to 10% of psychiatric outpatients and 20% of inpatients.[1] BPD is associated with severe psychosocial impairment and morbidity, greater usage of mental health resources, and a high mortality rate.[1,2] These data make a compelling case for the development of empirically tested prevention and early intervention programs.[1]

Rationale for prevention and early intervention

Diagnosing BPD in adolescence

BPD usually emerges during adolescence, and adolescents with BPD commonly seek help.[3,4] However, the condition often goes unrecognised,[4] because diagnosis of PD in this age group is controversial.[5] Nevertheless, a substantial body of evidence indicates that the diagnostic criteria for BPD (and other PDs) are as reliable, valid and stable before age 18 years as they are in adulthood.[4,6,7] Importantly, BPD in adolescence is associated with serious morbidity[4] that appears to persist for decades.[8]

BPD is conservatively estimated to affect between 0.9%[9] and 3%[10] of community-dwelling teenagers (similar to the prevalence in adults[2]), with more liberal definitions (lower symptom thresholds) yielding a prevalence of up to 11%–14%.[10,11] Mean levels of BPD traits are highest in early adolescence and decline for most people at least into their late 20s,[8] leaving in their wake a subgroup with high levels of BPD traits and disability.[12] BPD traits in young people also show considerable flexibility and malleability,[13] making this a key period in which to intervene.

Psychosocial functioning and longitudinal outcome of BPD in young people

Although the natural history of BPD traits in adolescence is toward attenuation over subsequent years, this does not imply "recovery". Adolescents with BPD have been found to have the broadest range of functional impairment of all PDs on measures of social impairment, school or work problems, psychiatric symptoms and antisocial behaviour.[10] Also, our group has shown that the BPD diagnosis defines a group of adolescent patients with the highest levels of psychopathology and the most severe psychosocial dysfunction (a pattern similar to that found in studies of adults with BPD), compared with adolescents with other PDs or without PD.[4] Moreover, in this study, BPD was a significant predictor of psychiatric symptoms and adaptive functioning, over and above Axis I disorders (eg, depression, substance use) and other PD diagnoses, indicating that BPD in adolescence is not reducible to Axis I diagnoses.

Wide-ranging prospective data from the Children in the Community (CIC) Study[8] indicate that high symptom levels of any PD (including BPD) in adolescence have negative repercussions over the subsequent 10–20 years, and that these repercussions are often more serious or pervasive than those associated with Axis I disorders. In many cases, PDs might account for the long-term impairment associated with Axis I disorders, with which they often co-occur.

Elevated BPD symptom levels in adolescence have been shown to be an independent risk factor for substance-use disorders during early adulthood.[14] Furthermore, Cluster B (borderline, antisocial, narcissistic and histrionic) PD symptoms in adolescence increase the risk of violent behaviour, which also persists into early adulthood.[15] In a community sample of 16–19-year-old women, Cluster B PD symptoms were associated with increases in depressive symptoms over a 2-year period.[16] Also, at the 2-year follow-up, former adolescent inpatients with PDs (50% were diagnosed with BPD) used more illicit drugs and required more inpatient treatment than adolescent inpatients without PDs.[17] BPD symptoms at 22 years of age are also independently associated with significant reductions in quality of life 11 years later.[18] Moreover, BPD symptoms during the transition to early adulthood predict romantic dysfunction over a 4-year period (romantic chronic stress, conflicts, partner dissatisfaction, abuse, and unwanted pregnancy), although the associations were not unique to BPD.[19] They also predict greater conflict with romantic partners.[20]

Prospective risk factors

Publications from the CIC Study have identified childhood risk factors for any PD in young adults.[8] However, data on true causal risk factors for BPD (ie, prospectively assessed factors that precede the emergence of the BPD phenotype[21]) are meagre.

***Diagnostic and statistical manual of mental disorders* 4th edition (DSM-IV) criteria for borderline personality disorder (adapted by Lieb and colleagues)[1]**

Affective criteria

- Inappropriate intense anger or difficulty controlling anger (eg, frequent displays of temper, constant anger, recurrent physical fights)
- Chronic feelings of emptiness
- 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)

Cognitive criteria

- Transient stress-related paranoid ideation or severe dissociative symptoms
- Identity disturbance: striking and persistent unstable self-image or sense of self

Behavioural criteria (forms of impulsivity)

- Recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour
- Impulsivity in at least two areas that are potentially self-damaging that do not include suicidal or self-mutilating behaviour

Interpersonal criteria

- Frantic efforts to avoid real or imagined abandonment that do not include suicidal or self-mutilating behaviour
- A pattern of unstable and intense interpersonal relationships characterised by alternating between extremes of idealisation and devaluation

* Five of the nine criteria are required to diagnose borderline personality disorder.

Childhood abuse, although common in BPD, is neither necessary nor sufficient for the development of BPD.[22] However, in the only prospective studies of risk factors for specific PDs, the CIC group found that officially documented physical or sexual abuse or neglect in children were each associated with elevated BPD symptom levels during early adulthood.[23] They also found that maternal inconsistency in childrearing predicted the persistence or emergence of BPD (but not of any other PD) 2.5 years later, but only in the presence of high levels of maternal overinvolvement.[24] Most recently, the CIC Study reported that, when childhood behavioural or emotional problems and parental psychiatric disorders were controlled for statistically, 10 types of parenting behaviour, evident during the childrearing years, were prospectively associated with an elevated risk of PD in the children of these parents on reaching adulthood.[25] Moreover, aversive parental behaviour and low levels of parental affection or nurturing during the childrearing years were each associated with several specific PDs, including BPD.

Precursor signs and symptoms

There are few signs and symptoms that predict the onset of any mental disorder with certainty. The signs and symptoms from a diagnostic cluster that precede a disorder but do not predict its onset with certainty are termed *precursor signs and symptoms*.[26]

Childhood or adolescent disruptive behaviour disorders[8] and depressive symptoms[8,9] have been identified as predictors of young adult PD of any type. Substance-use disorders during adolescence, particularly alcohol-use disorders, are one of the few specific predictors of young adult BPD.[27] Critically, the only study to have measured childhood or adolescent PD, as a predictor of later PD, found that symptoms of PD were the strongest predictors of later PD, over and above disruptive behaviour disorders and depressive symptoms,[8] although the predictions are at the cluster level, and not for individual PDs (*Diagnostic and statistical manual of mental disorders*, 4th edition [DSM-IV]). This same sample showed an increasing skew in the distribution of data over time,[12] suggesting that adolescents with elevated BPD trait levels are an important group, possibly the most important group, from which adult BPD arises, although this is unlikely to represent the only pathway to adult BPD.

Specialised interventions

Historically, clinicians have accepted the intractability of BPD and its poor outcome. However, the emerging controlled trial literature for BPD (reviewed by Lieb et al[1] and Binks et al[28]) has begun to counteract these beliefs. Recent data from well designed, "second generation" studies report positive outcomes (fewer suicidal behaviours, less emergency department use, and fewer hospitalisations[29]) for specialised interventions that might be successfully adapted for use in prevention and early intervention. To our knowledge, our group has conducted the only randomised controlled early intervention trial specifically for BPD, with preliminary results favouring a specialised intervention, based on cognitive analytic therapy, over manual-based good clinical care.[30]

A proposal for prevention and early intervention

Universal and selective prevention

The data given above describing specific risk factors, pathways or mechanisms for the development of BPD are inadequate, so that currently it is not feasible to use these as a basis for preventive strategies. Moreover, it is difficult to translate many of these findings into meaningful targets for intervention, as many risk factors are fixed exposures, or require major social policy and economic changes with a long timetable for implementation, if they are to occur at all. Also, not only are these risk factors associated with diverse outcomes other than BPD, but most people exposed to these risk factors, such as early trauma, do not develop psychopathology, let alone BPD.[8,22] Therefore, interventions aimed at reducing exposure to these factors (*universal prevention*[21]), or targeting those exposed to them (*selective prevention*[21]), must have broader aims than the prevention of BPD alone. Interventions should include the full range of psychopathology and the adverse outcomes associated with these risk factors, and existing interventions for mental disorders and social problems might usefully measure BPD as an outcome.

Indicated prevention and early intervention

Targeting groups with precursor signs and symptoms (*indicated prevention*[21]) appears feasible using the available data. However, this would still need to focus on diverse outcomes (albeit with a

narrower focus than universal or selective programs) that include BPD. The data pertaining to precursor signs and symptoms improve our capacity to focus on clinically relevant syndromes, but still do not allow a specific or specialised focus on BPD (measured dimensionally or categorically) or the traits underlying BPD.

A diagnosis of BPD in adolescence appears to be as valid and reliable as it is in adulthood, and young people with BPD seek clinical help, even if their condition is unrecognised by clinicians.[3,4] Furthermore, adolescents displaying BPD traits form the major group from which the young adult BPD phenotype arises.[12] These findings make early intervention for first presentation BPD the "best bet" for immediate action. Research studies could be mounted immediately, using available interventions and resources that already exist in many health systems in industrialised countries.

Risks and benefits of early intervention

Early intervention for BPD holds great promise, but it also has the potential to be undermined by unrealistic expectations. Possible aims might include ameliorating borderline and/or general psychopathology, improving psychosocial functioning, along with reducing risks for Axis I disorders, violence, offending behaviour, suicide, self-harm and interpersonal conflict. Other goals might include reducing health service use and iatrogenic complications, and avoiding the heavy dependency on the health system that is characteristic of patients with chronic BPD. This might require specific professional training programs, challenging clinicians' attitudes and defensive practices, as well as public "mental health literacy" campaigns.

These potential benefits must be weighed up against the potential risks. It is unclear whether detection and intervention will always bring benefits, as BPD is a highly stigmatised label, with the potential for iatrogenic harm.[31] It is important not only to avoid the family-blaming of bygone eras, but also to respect, involve, and provide support to families. Finally, cost-effectiveness will also need to be demonstrated.

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Competing interests

None identified.

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