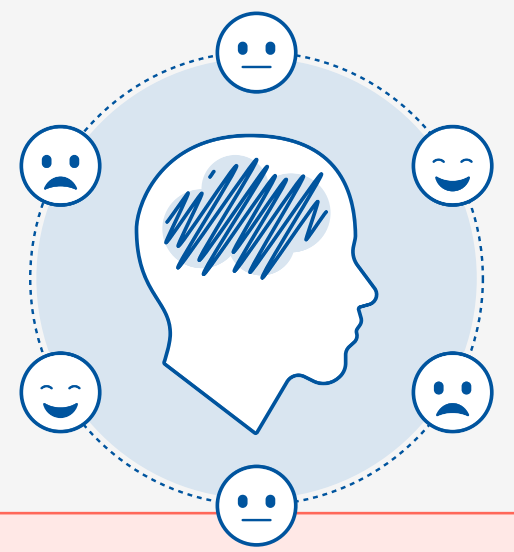
Borderline personality disorder

Key information for clinicians from the *Lancet* Seminar



Diagnosis

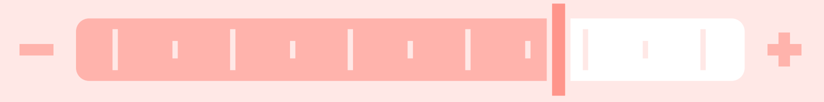
Two models are recommended: the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5), and the International Classification of Diseases, 11th revision (ICD-11).

DSM-5: borderline personality disorder

Maintains the traditional method of using nine **polythetic criteria**, of which **at least five must be met** to receive a diagnosis

ICD-11: borderline pattern

The general severity of a person's personality disorder and prominent personality traits are determined. A 'borderline pattern' can be specified.



Core assessment criteria used

Criterion	DSM-5	ICD-11
Fear of abandonment	✓	✓
Unstable relationships	✓	✓
Unstable self-image	✓	✓
Impulsivity	✓	✓
Self-harm	✓	✓
Mood instability	✓	✓
Feelings of emptiness	✓	✓
Inappropriate anger	✓	✓
Dissociation/transient paranoid ideation	✓	✓

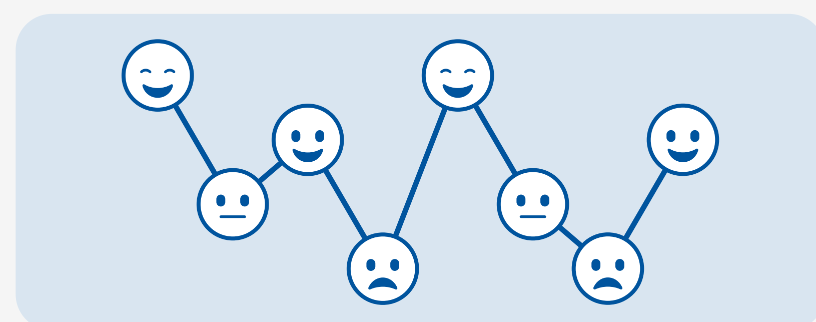
Other criteria

Six additional manifestations of borderline pattern are are often seen, not all of which may be present in a given individual at a given time:

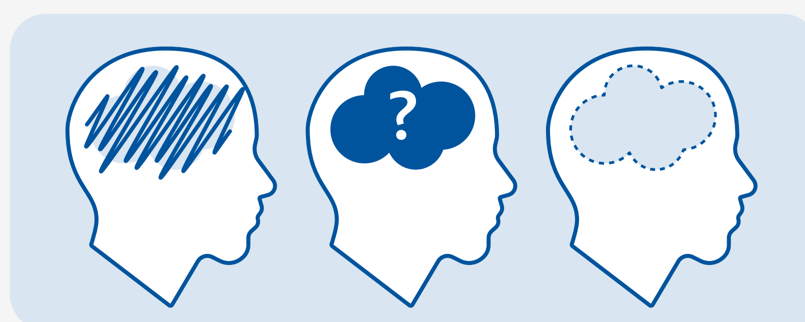
Criterion	DSM-5	ICD-11
A view of the self as inadequate, bad, guilty, disgusting, and contemptible		✓
An experience of the self as profoundly different and isolated from others		✓
A painful sense of alienation and pervasive loneliness		✓
Proneness to rejection hypersensitivity		✓
Problems in establishing and maintaining consistent, appropriate levels of trust in interpersonal relationships		✓
Frequent misinterpretation of social signals		✓

Core characteristics

BPD incorporates three core characteristic domains:



Intense and rapidly changing emotions including impulsivity



Unstable and inconsistent self-identity

Problems with interpersonal relations

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Prevalence and remission

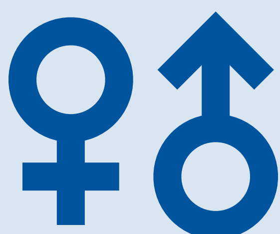
Prevalence

Community setting

Reviews suggest community point prevalence of BPD in adults of 0·7 to 2·7%, 2 to 3% in adolescents (12 to 17 years), and 0·4% in older adults (40+ years).

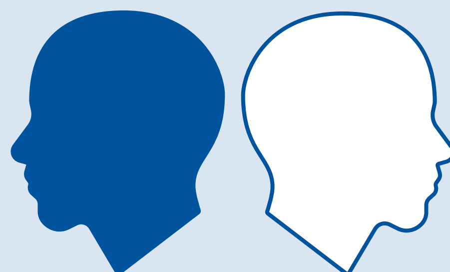
Clinical setting

Prevalence is substantially increased in clinical settings, when compared to that in a community setting.



Gender

Higher rates seen in women than in men in clinical settings, and mixed results for a gender difference in the community.

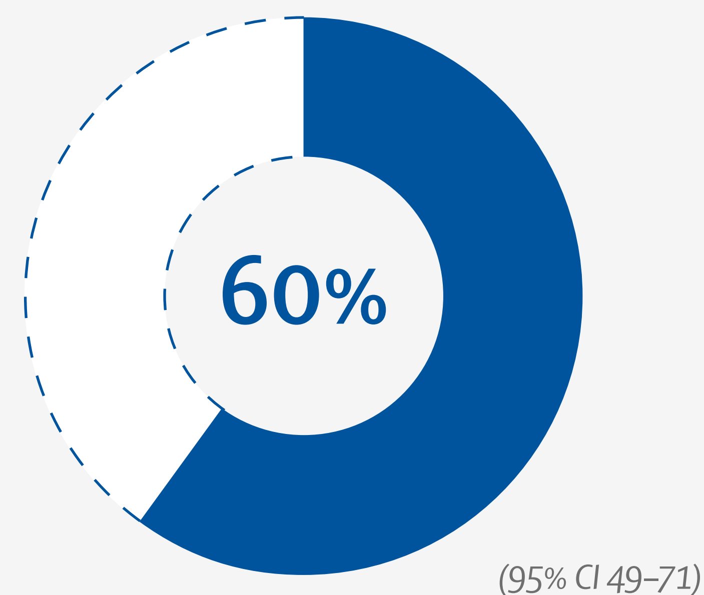


Race and ethnicity

Most studies do not show systematic differences; however, studies are few, warranting urgent research attention.

Remission

Over an observation period of 5 to 14·4 years, a recent review suggested a mean diagnostic remission rate of:



(95% CI 49–71)

Early diagnosis and intervention

Symptoms of BPD peak in late adolescence and early adulthood, and groups with a younger mean age were more likely to show high remission rate — underscoring the importance of early diagnosis and intervention.

Management strategies

For acute management

Psychosocial interventions

- The first priority must be **addressing crisis behaviours** such as suicide attempts, non-suicidal self-injury, and serious attacks on other people.
- Crisis intervention should be **based on a problem analysis**, should mainly focus on **concrete problem-solving**, and should be offered on an outpatient basis when possible.
- If inpatient intervention is needed, **keep it as short as possible**, and start planning for discharge immediately.
- Do not initiate inpatient crisis intervention based on behaviour that is not life-threatening.

Medication

- **Not to be used in place of psychosocial interventions.**
- Consider concurrent **alcohol or illicit drug use** in the planning of potential drug treatment.
- Do not use medications that are unsafe in case of overdose or have high addictive potential.
- Do not initiate drug treatment without disclosing potential effects and adverse effects to the patient, and inform all involved service providers about medication changes.

For long-term treatment

Psychosocial and somatic management

- **Start an evidence-based treatment program as early as possible** to avoid chronic progression of the disorder.
- If needed**, provide education** on BPD and **training in adequate interpersonal behaviour** to significant others.
- **Inform patients** about different specialist treatments.
- Define the treatment frame and establish psychosocial care if no specialist treatment is available.
- Change treatment or therapist if there is no progress within 6 months.
- **Do not excessively focus on suicidality.**
- **Encourage patients to get involved in somatic prevention programmes** and yearly check-ups of somatic diseases, or to seek help in case of somatic problems.

Medication

- **Do not use medication as the sole therapy approach** — use only as an add-on to psychosocial interventions.
- **Review drug prescriptions on a regular basis**, and include patient in discussion when deciding about medication use.

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