Borderline Personality Disorder: Diagnosis and Management in Primary Care

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Patients with borderline personality disorder frequently present to primary care physicians. However, the personality disorder, while complicating medical treatment, is often undetected. Symptoms and clinical presentations of this disorder are described. Common co-morbid psychiatric conditions associated with borderline personality disorder include depression and substance abuse. Physically self-damaging behaviors are also common among patients with this disorder. Guidelines for managing these patients in the hospital and ambulatory care clinic are provided.
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Patients with borderline personality disorder (BPD) frequently present to primary care physicians. However, these patients' personality disorders are often not recognized.[1] Little data are available about the prevalence or clinical picture of these patients outside of psychiatric settings. The primary care physician may encounter BPD patients in the ambulatory care setting with one of three common presentations: (1) the patient with severe yet acute depression in which depression is more of a mood state than a set of vegetative symptoms[1,2]; (2) the drug-seeking patient who has a history of substance abuse[2]; and (3) the demanding and aggressive patient who idealizes or devalues the physician's interpersonal skills or competence or both. In the inpatient setting, BPD emerges in the form of management problems. These patients may be disruptive, demanding, and noncompliant.[1] They often successfully provoke conflicts between physicians and their nursing staffs. Lastly, these patients are encountered in the emergency department, where they are most likely to be seen after a suicide attempt.[3] Although suicide should always be managed as a life-threatening condition, the BPD patient often exhibits self-mutilative behavior that is associated with a sense of psychological relief[3] or that communicates an interpersonal message. These suicidal episodes are often impulsive, and the patients may readily bring themselves to the emergency department.[3]

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The purpose of this paper is to describe the diagnosis of BPD and its implications for primary care physicians. Clinical encounters with these patients may be confusing and emotionally intense. It is valuable for the physician to understand the behavior of these patients as reflecting a more pervasive personality syndrome. Equipped with this knowledge, the primary care physician can develop more effective strategies for managing BPD patients.

Diagnostic Criteria

The criteria for borderline personality disorder as defined by the *Diagnostic and Statistical Manual of Mental Disorders,* Third Edition, Revised (DSM-III-R),[4] are presented in Table 1. As is the case with all personality disorders, these borderline features emerge in a long-standing, maladaptive pattern of perceiving the world and relating to others. Personality disorders are most likely to be evident in interpersonal relationships.[4]

Epidemiology

Data on the prevalence of personality disorders, in general, is somewhat inconclusive. DSM-III-R[4] states that the disorder is "apparently common" in an estimated 5% to 10% of the general population.[5] The disorder is significantly more prevalent among women than men.[4] Developmentally, the disorder first becomes evident in mid- to late adolescence.[4,5] It has been suggested that in contrast to patients with other personality disorders, BPD patients are likely to enter the mental health or substance

Table 1. DSM-III-R Criteria for Borderline Personality Disorder*

A pervasive pattern of instability of mood, interpersonal relationships, and self-image, beginning by early adulthood and present in a variety of contexts, as indicated by at least *five* of the following:

1. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of overidealization and devaluation
2. Impulsiveness in at least two areas that are potentially self-damaging: eg, spending, sex, substance use, shoplifting, reckless driving, binge eating (Do not include suicidal or self-mutilating behavior covered in [5])
3. Affective instability; marked shifts from baseline mood to depression, irritability, or anxiety, usually lasting a few hours and only rarely more than a few days
4. Inappropriate, intense anger or lack of control of anger, eg, frequent displays of temper, constant anger, recurrent physical fights
5. Recurrent suicidal threats, gestures, or behavior, or self-mutilating behavior
6. Marked and persistent identity disturbance manifested by uncertainty about at least two of the following: self-image, sexual orientation, long-term goals or career choice, type of friends desired, preferred values
7. Chronic feelings of emptiness or boredom
8. Frantic efforts to avoid real or imagined abandonment (Do not include suicidal or self-mutilating behavior covered in [5])

*American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised.* Washington, DC: American Psychiatric Association, 1987:347. Reprinted with permission.

abuse treatment system during at least one period of their lifetime. Often the chaotic and intense interpersonal relationships that they exhibit socially are also enacted in psychotherapy.[3] Treatment encounters may be brief, intense, and unproductive.[3] However, a number of these patients have remained in long-term psychotherapy. Thus, a good deal is known about the clinical picture and history of this condition.[6,7]

Etiology

Although DSM-III-R describes the disorder, it does not provide an etiological explanation. At present, there is no consensus on the etiology of this disorder. Although it has been suggested that borderline personality may have a nonspecific hereditary component in common with affective disorders, schizophrenia, or both, the evidence for genetic transmission is unclear.[8] However, as is the case with personality disorders in general, the BPD patient has usually experienced a dysfunctional developmental history.[9,10] Psychodynamic formulations center on parental neglect[11] or overinvolvement as well as the unpredictable oscillation between these two extremes.[12] Disruptive separation or permanent loss of the primary caretaker appears to be a frequent factor in these patients' developmental histories.[10,11] Recent studies have revealed a high frequency of child abuse, both physical and sexual, among adults with BPD.[9,13] Herman et al[10] found that 71% of BPD patients in an ambulatory mental health center reported histories of physical abuse, and 68% reported sexual abuse.

Clinical Picture

While the etiology and diagnosis of borderline personality are complicated, the term *instability* is a concise summary label.[3,5] This instability exists in identity, mood, and relationships. While this is a clinically useful concept, BPD is a heterogeneous condition, and instability will be manifested in a range of behaviors.[14,15]

Identity disturbance may take a variety of forms. The clinician may note that the patient does not have a clear focus for life goals toward a new career.[11] One week the patient may be planning on taking courses in college toward a new career, the next week planning to leave town to look for a new job, and the following week deciding to stay at the old job. This disturbance may take the form of merging with someone else's identity such that the patient becomes extremely dependent on that individual.[11] Patients with BPD may feel that their lives and plans are inextricably dependent on the desires of others. The instability in identity can also extend to their own self-concepts. They are likely to view themselves alternately as "all good" or "all bad." Patients with BPD may reflect this instability in their own lives by being "good" in their work situations, in which they perform very competently, and "bad" in their interpersonal relationships, in which they are moody, demanding, and unpredictable.[11]

A second common feature of BPD is intolerance of being alone. Because of this, patients devote considerable energy to avoiding real or imagined abandonment. This pattern may emerge in several ways. For example, a man with BPD may call his girlfriend 20 times a day, go into a panic or rage if she is not immediately available,[11] and ask for a minute-by-minute account of her day. A pattern of instant intimacy is also common. The physician may encounter a BPD patient who asks a large number of personal questions such as where the physician lives, whether he or she is married, and how many children the physician has. This information typically has little relevance to the physician's ability to treat the patient's medical problems, and because of the patient's neediness for interpersonal contact, the physician is likely to experience a loss of normal social and clinical distance.

Patients with BPD may also exhibit a defense called

"splitting," the inability to integrate contradictory experiences.[16] When these patients make a mistake in a work situation or disappoint someone, they may become severely self-deprecating. The patients' view of themselves may dramatically oscillate between one of almost narcissistic entitlement and one of severe self-criticism. This intrapsychic process is also enacted interpersonally. The process of idealization alternating with devaluation is a common form that splitting takes. It may also become evident in an inpatient setting when a consultant and a primary care physician are working cooperatively with a BPD patient. The patient may label the consulting physician as cold, rejecting, and incompetent, while viewing the primary care physician as extremely sensitive and skillful.[1]

The primary care physician who sees a BPD patient on a regular basis may inadvertently be a focus for this symptom. For example, the physician who generally devotes considerable time to the BPD patient may find that on a day when he or she is somewhat rushed, the patient reacts with a barrage of criticism and hostility, effectively ignoring the previously good physician-patient relationship.

The splitting process often results in intense and unstable relationships.[3] In their personal lives, BPD patients often experience intense conflicts, which may include physical violence.[17] This divisiveness alternates with equally intense reconciliation. This pattern may be enacted with spouses, children, and lovers. The clinician is frequently surprised by the degree of rage that a BPD patient may feel toward a spouse or lover while simultaneously clinging to the relationship. Again, this pattern may be enacted with the primary care physician. The physician may experience the BPD patient as extremely critical and questioning of his or her professional competence. As a result, the physician may suggest that the patient transfer to another physician. The physician may be surprised to find that, despite the onslaught of criticism, the patient has no desire to change physicians.

The BPD patient may also demonstrate significant deficits in the area of impulse control.[3] These impulse control problems may take a number of forms including excessive drinking, drug use, overeating, overspending, and sexual acting out.[2] In general, these impulsive periods often follow an interpersonal loss and can be seen as a means of managing unpleasant affective states such as anxiety or dysphoria.

Physically self-damaging behaviors are also a common symptom of BPD.[4] These self-destructive acts have an unusual quality that is pathognomonic of the borderline personality syndrome: BPD patients may engage in behaviors such as slashing their wrists with razor blades, inflicting burns with cigarettes or lighters, or becoming intoxicated and driving a car at high speeds. While the intent appears suicidal, the BPD patient is often not intending death.[3] Instead, the BPD patient often seeks an experience of physical pain or distress that, in turn, reduces tension and may briefly alleviate guilt.[3,11] These self-destructive acts frequently occur immediately after the patient has engaged in some form of impulsive acting out or has had a major interpersonal conflict.

The behaviors described represent several perspectives on BPD including cognitive,[18] psychodynamic,[11,16] and interpersonal.[19] These characteristics will not be present or evident in the same degree in all BPD patients. For example, many patients with this disorder maintain excellent long-term work relationships but cannot sustain intimacy in their personal lives. Similarly, some BPD patients will consistently respond to threatened abandonment by drinking, whereas others will engage in self-mutilation.

Major depressive disorder is the most common comorbid psychiatric condition with borderline personality. It has been estimated that there is a 40% to 60% overlap between depression and BPD.[20,21] However, other BPD patients will exhibit anxiety as the primary affective state.[21] Somatoform disorders and substance abuse or dependence are also common diagnoses that occur with BPD.[1,2,11]

Clinical Cases

The following cases involved patients with BPD who presented in primary care settings.

Patient 1

The patient was a 29-year-old white married woman who presented at the ambulatory care clinic, tearful and despondent. She said that she felt overwhelmed and was experiencing headaches. She stated that during the previous week she had quit a job after an altercation with a supervisor. The patient reported that she had held approximately eight jobs during the previous 3 years and either had been fired or had abruptly quit after some interpersonal conflict. She said that her stress was compounded by the fact that her husband did not sympathize with her work difficulties and was currently angry with her for quitting because of the resultant loss of income. She was ambivalent toward her marriage and said that she oscillated between loving and hating her husband several times during the course of each day.

Further inquiry revealed that the patient had been using pain medication, including Darvocet and Percocet, fairly regularly for the previous 5 years. She said that she

obtained the prescriptions from different physicians for a variety of conditions including painful menstruation, headaches, and backaches. The patient also said that she smoked 1 to 2 marijuana cigarettes per day. She was vague about her drinking history. She indicated that she periodically went to bars and drank to the point of intoxication, but she did not provide much information about the frequency of these episodes.

The patient married at 16 years of age after becoming pregnant. She said that her mother "threw her out of the house" on learning that she was pregnant. The patient's first husband was abusive, and the marriage ended after approximately 2 years. Soon after, the patient met her second husband to whom she was still married. This marriage was characterized by ongoing conflict, several reported extramarital affairs by both spouses, and numerous separations.

The patient had one previous psychiatric hospitalization of 10 days' duration, which occurred approximately 7 years before. Over the past 10 years, the patient made several suicide attempts with small amounts of nonprescription medication. She said that she was seen by a psychiatrist approximately 1½ years before the current consultation and was placed on an antidepressant medication, which she stopped taking after 1 week.

Comment. The patient's difficulty in generating a cohesive history could have been attributed to subtle cognitive deficits such as dissociative states, which have been associated with BPD.[22] The patient described having episodes of intense anger, impulsive patterns of sex and substance abuse, suicidal behavior, unstable work relationships, substantial marital conflict, and idealization alternating with devaluation, which are all DSM-III-R symptoms of borderline personality disorder.

Before reaching a diagnosis of BPD, it was necessary to consider several other conditions. This patient did exhibit substance abuse as a co-morbid condition. Although the patient's poor work history and pattern of soliciting controlled substances from multiple physicians was consistent with an antisocial personality, the presence of manipulative suicide attempts, intense affect, and ability to maintain a long-term (albeit conflictual) relationship with her husband was more compatible with a diagnosis of BPD.

The physician's initial goal was to develop rapport with the patient in order to facilitate substance abuse treatment. The patient's entry into a drug treatment program required four family practice clinic visits over the span of several months, during which her physician encouraged her to seek help for her problem. Stone[7] has recently documented the importance of aggressively treating substance abuse in patients with BPD.

Patient 2

The patient was a 22-year-old white female college student who came to the emergency room after overdosing with approximately 25 nonprescription sleeping pills. She was stuporous and exhibited a number of self-inflicted cuts and scratches on the inside of her arms. She indicated that the overdose had been prompted by feeling "empty" because her roommate was rarely present. The roommate had recently begun staying overnight with a boyfriend. Approximately 20 minutes after ingesting the medication, the patient had asked another student to take her to the hospital. The patient indicated that she had begun scratching her arms with razor blades 2 months ago. She stated that the initial episode of self-mutilation occurred after a sexual encounter with a married man she had just met. She expressed a mixture of guilt and anger about the affair.

The patient was the youngest of two children. Her parents resided in a city approximately 200 miles away from the university. The patient described her mother as overprotective and as having actively discouraged the patient from moving away.

The patient did not report any history of psychiatric illness. On mental status examination, she was somewhat stuporous. Otherwise, her mood was mildly dysphoric and her affect was somewhat hostile. She indicated that she took the pills because she wanted to "feel something." When pressed, she said that she did not want to die, but that she just felt empty. The patient stated that "everything is OK now" and became extremely angry when the physician indicated that it would be necessary for him to admit her to the hospital for psychiatric evaluation. No auditory or visual hallucinations were noted. The patient related a history over the previous several years of binge eating when she felt depressed or anxious. A review of her functioning during the past 2 weeks did not reveal an obvious depressive syndrome. The patient was admitted to psychiatry for observation.

Comment. Although major depression was considered as a possible diagnosis for this patient, she did not meet DSM-III-R criteria for that disorder. The patient did exhibit BPD features. Some of her symptoms, however, such as self-mutilation, appeared to be of fairly recent onset. The patient's self-mutilative behavior appeared to be associated with guilt resulting from impulsive sexual behavior. This pattern of self-punishment is a common dynamic in persons with BPD and is almost exclusively found with this disease. Other BPD features exhibited by this patient included binge eating, anger control problems, emptiness, and difficulty in tolerating being alone. The patient's apparent overinvolvement

with her mother, although not a DSM-III-R symptom, is also highly prevalent among persons with BPD.[19]

In contrast to depressed persons who have relatively clear suicidal ideation, the BPD patient's self-mutilative behavior often serves to reduce guilt without death as an intent.[3] The presence of diminished impulse control among BPD patients, however, may lead to inadvertent death. Patients with serious self-destructive behavior should always be evaluated for inpatient psychiatric admission.

Patient 3

This patient was a 32-year-old white woman who was seen in the ambulatory care clinic. She had an extensive history of both insulin-dependent diabetes mellitus and hypertension, which had both been poorly controlled. The patient's presenting concern was frequent headaches.

By way of social history, the patient reported that she had been married for approximately 12 years. She and her husband had separated four or five times. The patient reported that she had a 13-year-old son and a 5-year-old daughter. The patient described an intermittent work history. She stated that she had worked as an aide in a number of nursing homes, and that her longest period of employment had been approximately 6 months. She said that she drank to the point of intoxication at least twice per month. She also reported that she smoked marijuana about 4 days out of the week. She stated that for approximately the past 10 years, she had frequently gone to bars and left with various men. These episodes were generally one-night sexual encounters. The patient indicated that when she was angry with her husband or was lonely, the pattern of binge drinking and having brief affairs tended to emerge.

During the interview, she exhibited considerable emotional lability, vacillating from anger to tearfulness to laughter. The patient indicated that she was supposed to be taking insulin on a daily basis, but was not taking it consistently and had not taken any for the past 3 weeks. She also stated that medication had been prescribed for hypertension, but that she was not taking it regularly either. The patient was not suicidal; however, she described cutting her wrists several times in the past. She reported frequent crying episodes and some fatigue, but no other depressive symptoms.

Comment. Acting out as an unconscious strategy for managing loneliness or potential abandonment is a common process with BPD patients. In addition to substance abuse, this patient demonstrated how BPD may interfere with treatment of chronic medical problems. It is likely that, psychologically, noncompliance with medication served a function similar to the patient's other self-destructive behaviors. The initial strategy in managing the patient was to develop a consistent relationship with the primary care physician, who encouraged her to ventilate her feelings but who also set specific expectations concerning medication compliance. The physician also discussed the self-destructive theme that he had identified, and explained that it had been manifested in the patient's noncompliance. The patient was referred to a psychologist for supportive psychotherapy. Her overall psychosocial functioning did not dramatically improve; however, within 3 to 4 months after the initial contact, her diabetes was under better control.

Course of the Syndrome

Despite the large number of patients with BPD who receive both inpatient and outpatient psychiatric treatment, relatively little is known about the course of this disorder. Existing studies traditionally follow BPD patients after they have been discharged from an inpatient program. The majority of these patients studied continue to receive some form of psychotherapy for periods throughout their lifetime.[7,23]

Drawing on a cohort of patients with BPD who were discharged from a long-term inpatient facility, McGlashan[24] sketched a life history of the disorder. Generally, these patients manifested poor work and social functioning through their 20s and early 30s. Functioning improved and stabilized during their 40s. However, a subgroup of patients deteriorated during their late 40s and early 50s, usually in response to a divorce, death of a spouse, or dissolution of a significant relationship.[24]

The lifetime rate of completed suicide among persons with BPD is between 6% and 10%.[7,23,25] However, BPD patients with co-morbid conditions such as major depression and substance abuse manifest a substantially higher suicide rate. Patients with a concomitant depressive disorder exhibited a 15% to 20% rate of completed suicide.[7] Particularly striking is the 38% suicide rate during a 5-year period among female patients with BPD who had both co-morbid major affective disorder and substance abuse.[7]

Treatment

Psychological treatment of BPD patients has included psychodynamic, cognitive-behavioral, family, and group therapies. There have been very few rigorous empirical outcome studies of treatment for BPD patients. The majority of treatment literature for this condition describes long-term individual psychodynamic psychother-

apy.[16,26] Several studies have compared supportive therapy, focusing on empathic reassurance and problem-solving about issues that arise in the patient's daily life, with expressive therapy that resembles more traditional psychodynamic therapy, including interpretation and linking the patient's internal states to his or her behavior.[26] Patients with BPD who had better quality interpersonal relationships appeared to improve more with expressive therapy, while patients who had poorer social connections improved more in supportive treatment.[25]

With respect to pharmacotherapy, it is important to recognize that personality disorders alone are not usually amenable to psychoactive drug treatment. These disorders are the product of a long social learning history rather than a biochemical or physiological process. However, BPD patients with common co-morbid conditions such as major depression or generalized anxiety often do benefit from medication.[27,28] Although controlled studies of medication response in BPD patients are few, there are suggestions that depressed patients with vegetative symptoms demonstrate improvement with tricyclic antidepressants and possibly with fluoxetine.[7] Similarly, BPD patients with generalized anxiety disorder in which autonomic symptoms predominate may benefit from short-term use of minor tranquilizers. Because BPD patients are at significant risk of committing suicide, tricyclics should be prescribed with caution and patients should be closely monitored. Similarly, the high prevalence of substance abuse among these patients suggests that anxiolytic medications such as alprazolam and diazepam should be used with caution.[8,28]

Management in the Primary Care Setting

The primary care physician, while generally not in a position to perform long-term psychotherapy, will frequently encounter patients with BPD in practice. Table 2 presents a list of presenting clinical issues commonly associated with BPD patients in primary care settings.

As noted earlier, these patients rarely present clinically with BPD as a problem, but may exhibit depression, anxiety, or medical problems associated with substance abuse. In addition, the presence of BPD may complicate the treatment of nonpsychiatric medical problems. While the heterogeneity of this condition does not lend itself to a fixed protocol, some suggestions are offered below and summarized in Table 3.

1. Accurate diagnosis of depression and substance abuse may be more difficult among patients with concurrent BPD. Clinically, depression with an underlying personality disorder often presents somewhat differently from the classic acute depressive episode described in DSM-III-R. Generally, BPD patients have an extensive history of poor psychosocial functioning, with a similarly long history of dysphoric mood. With BPD patients, depression may take the form of a mood state rather than an easily identified set of vegetative symptoms. The likelihood of an underlying personality disorder should be one consideration when a patient does not respond to a reasonable trial of antidepressant medication. Clinically depressed patients with underlying BPD are likely to respond to antidepressants and exhibit improved vegetative functioning; however, mood swings and impaired psychosocial functioning are likely to persist.

Among BPD patients with concurrent substance abuse, the pattern of abuse is likely to be episodic rather than continuous. Patients with BPD are very likely to engage in binges of drinking and drug use, and they therefore usually do not meet DSM-III-R criteria for substance dependence but do meet criteria for substance abuse.

2. The clinician should try to remain emotionally detached and neutral.[3] The physician may find that the BPD patient actively provokes him or her. The physician's emotional reaction may be to become angry or to reject the patient. It is important for the physician to recognize that the provocative behavior of such patients is part of their psychiatric condition and should be responded to in the same way as any other symptom. The level of emotional arousal is likely to be particularly high with the primary care physician since the physician is most likely to see them at crisis points.[1,3,11]

3. If the patient seems annoyed or angry with the physician, the physician should acknowledge these feelings.[3] The physician can then ask if there is anything that

Table 2. Clinical Issues Associated with Borderline Personality Disorder

- Clinical depression that is unresponsive to pharmacotherapy
- Manipulative suicide attempts
- Self-abusive behavior (eg, self-inflicted cuts or burns)
- Noncompliance with treatment for chronic or acute medical problems with little apparent concern about consequences
- Sense of entitlement, excessively demanding of physician time and attention
- Disproportionate, intense anger toward physician
- Broken bones or lacerations that were incurred during angry outbursts (eg, banging arm against a wall, smashing a window)
- Patient "splits" physicians (eg, primary physician characterized as "all good" and consulting physician characterized as "all bad")
- Physician becomes anxious or fearful of patient's emotional volatility

Table 3. Guidelines for Clinical Management of Patients with Borderline Personality Disorder in the Primary Care Setting

- Be aware that co-morbid borderline personality disorder may complicate accurate diagnosis of major depression and substance abuse.
- Remain emotionally neutral and avoid responding to provocation.
- Acknowledge the patient's anger, frustration, or annoyance.
- Respond to strong emotional outbursts with a verbal recognition of patient's feelings and a request for appropriate behavior.
- Actively structure the patient interview.
- Schedule patients with "abandonment issues" or somatization for frequent, brief office visits.
- Supportively confront medical noncompliance. Contracting with the patient may be helpful.
- Conduct physical examinations with a nurse present.
- Support psychotherapy for the patient.

he or she is doing that angers or agitates the patient. This response by the physician will enhance the patient's sense of control and decrease the patient's feelings of vulnerability.

4. The intense emotionality that many BPD patients exhibit is often initially overwhelming and anxiety-provoking for physicians and nurses. The response to the patient's emotional outbursts should include a recognition of the patient's feelings with a clear request for appropriate behavior ("I can see you are very angry. I can talk with you if you will lower your voice"). If the patient does not respond, the physician or nurse should terminate the conversation with the message that it will be resumed when the patient obtains some control.

5. The physician should actively structure the interview.[3] The thought processes of BPD patients are often diffuse. It is useful to give them a brief introduction, summary, and rationale for the clinical interview that you will be undertaking.[3] The greater the organization around the interview, the greater the level of security experienced by the BPD patient. This security should, in turn, diminish some of the clinician's anxiety regarding the patient's unpredictable volatility. For example, the physician should state, "First, I would like to ask you about your drug and alcohol use. Then I would like to ask you about your relationship with your husband." In addition, the clinician should label the patient's current behavior. A knowledge of the BPD patient's symptoms and dynamics will be extremely useful. This is particularly true for the patient's self-destructive acts, which may be experienced by the patient as frightening and masochistic self-injurious behavior. A primary care physician who is knowledgeable about the syndrome and who can communicate empathy and an understanding of the symptoms will greatly reduce the patient's fearfulness and dramatically increase rapport.

6. The BPD patient's fear of abandonment may be enacted with the primary care physician. The patient may repeatedly telephone the physician and appear in the office or emergency room as a means of "testing" the physician's availability.[11] The physician should verbally describe this pattern to the patient and label the underlying fear. It is often clinically useful and more efficient to schedule these patients for frequent brief office visits (eg, biweekly).

7. A similar clinical strategy with frequent office visits is useful for patients exhibiting BPD together with somatization disorder. For the patient with chronic rotating physical complaints, it is valuable to focus on a specific complaint at each visit in conjunction with a brief discussion of the patient's psychosocial circumstances. Over time, these patients may be able to appreciate the relationship between psychosocial stressors and somatic complaints.

8. The BPD patient with a chronic illness (eg, diabetes, hypertension) who is noncompliant should be supportively confronted. It is often therapeutic to label the self-destructive theme in the patient's noncompliant behavior. This should be followed by a discussion of the consequences of continued noncompliance and the physician's concern about the patient's health. Establishing a contract with the patient around compliance and appointments is often a valuable structuring device. It is often helpful to put these contracts in writing with a copy for the patient to take home.

9. When performing a physical examination, particularly a breast or pelvic examination, it is particularly important that the physician take all necessary precautions, including having a nurse present in the room. Patients with BPD have significant boundary problems and may misinterpret these procedures as indicative of a personal relationship rather than reflecting a medical examination.[29]

10. Once rapport has been established with the patient, the primary care physician may consider referring the patient for psychotherapy. Brief discussions of psychotherapy during the course of multiple office visits may be needed before the patient will seriously consider this option. Given the BPD patient's sensitivity to rejection, the physician should not present psychotherapy as a replacement for his or her own availability but, instead, as an additional support. It is helpful to predict to the patient that therapy will be difficult and that the patient is likely to get angry with the therapist and will want to stop treatment. Since this is, in reality, likely to happen, it will prepare the patient for when difficulty does occur in the psychotherapeutic relationship. In addition, it is

important for the primary care physician to support the patient's continued involvement in psychotherapy. This support can be provided simply by asking about the patient's course of psychotherapy and his or her feelings about it during each office visit. The patient may periodically deprecate the therapist or devalue the therapy. At these times, the physician should acknowledge the patient's discomfort while simultaneously continuing to support the patient's involvement in therapy.

Conclusions

Patients with BPD frequently present to primary care physicians. However, the personality disorder itself often remains undiagnosed. The presence of BPD confuses the clinical picture in diagnosing or treating the depression, anxiety, and substance abuse that are more readily apparent. In addition, the internal dynamics and behavior of these patients may interfere with the treatment of acute and chronic physical illness.

By developing a working clinical knowledge of this disorder, the primary care physician will, it is hoped, be able to develop rapport with these patients. In addition, an understanding of the borderline syndrome can reduce the confusion, anxiety, and frustration that physicians often experience with these patients. While it is unrealistic for primary care physicians to provide long-term psychotherapy for BPD patients, the family physician can have a therapeutic effect by following the guidelines described above. By serving as a consistent, yet firm, physician who will "call" the patient on his or her self-destructive behavior, the primary care physician will be providing valuable psychosocial therapy.

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