

# SCOPE

## 1 Guideline title

Borderline Personality Disorder: treatment and management

### 1.1 Short title

Borderline personality disorder (BPD)

## 2 Background

- a) The National Institute for Health and Clinical Excellence ('NICE' or 'the Institute') has commissioned the National Collaborating Centre for Mental Health to develop a clinical guideline on borderline personality disorder for use in the NHS in England and Wales. This follows referral of the topic by the Department of Health (see appendix). The guideline will provide recommendations for good practice that are based on the best available evidence of clinical and cost effectiveness.
- b) The Institute's clinical guidelines will support the implementation of National Service Frameworks (NSFs) in those aspects of care where a Framework has been published. The statements in each NSF reflect the evidence that was used at the time the Framework was prepared. The clinical guidelines and technology appraisals published by the Institute after an NSF has been issued will have the effect of updating the Framework.
- c) NICE clinical guidelines support the role of healthcare professionals in providing care in partnership with patients, taking account of their individual needs and preferences, and ensuring that patients (and their carers and families, where appropriate) can make informed decisions about their care and treatment.

### 3 Clinical need for the guideline

- a) Borderline personality disorder (BPD) is characterised by a pattern of instability of interpersonal relationships, self-image and affects, and by marked impulsivity. Its diagnosis does not imply any specific cause.
- b) Estimates of the prevalence of BPD vary between 0.7 and 2% in the general population. It is estimated to be present in 20% of in-patients in psychiatric wards and between 10 and 30% of out-patients. It is a disorder predominantly diagnosed in women (75%); although again estimates vary and most of these studies have been in clinical populations, where women predominate as they are more likely to seek treatment. Other estimates indicate that the rate in men (1%) is two and a half times that in women (0.4%). The prevalence of BPD is particularly high in the prison population; in England and Wales it is estimated to be 23% among male remand prisoners, 14% among sentenced male prisoners and 20% among female prisoners.
- c) BPD is defined descriptively, in terms of its associated impairments. There are two main sets of diagnostic criteria in current use, the International Classification of Mental and Behavioural Disorders 10th Revision (ICD-10) and the Diagnostic and Statistical Manual of Mental Disorders fourth edition (DSM-IV). ICD-10 uses the term emotionally unstable personality disorder, dividing this into two variants (impulsive type and borderline type) both of which share the general theme of impulsiveness and lack of self-control. The impulsive variant is characterised by a tendency to conflict and outbursts of anger or violence, difficulty in maintaining any course of action that offers no immediate reward, and instability of mood; the borderline variant is characterised by disturbances of self image, a tendency to unstable relationships, efforts to avoid abandonment, and threats or acts of self harm (including suicide). In DSM-IV, BPD is defined more broadly to include all of the features of the borderline variant of emotionally unstable personality disorder and most of the criteria for the impulsive variant. DSM-IV also defines all personality disorders as axis II

disorders. BPD is defined as a cluster B disorder ('dramatic, emotional or erratic' type) along with antisocial, histrionic and narcissistic personality disorders. There is substantial comorbidity of borderline personality disorder (BPD) with common mental disorders such as depressive illness, the range of anxiety disorders or substance misuse disorders.

- d) There is some divergence between ICD-10 and DSM-IV as to whether borderline/emotionally unstable personality disorder can be diagnosed in those younger than 18 years, and this may lead to uncertainties about the usage of the diagnosis in young people. In ICD-10 the disorder comes within the overall grouping of disorders of adult personality and behaviour, but DSM-IV specifies that BPD can be diagnosed in those younger than 18 if the features of the disorder have been present for at least 1 year.
- e) Specific causes of BPD have not been identified. Although the processes that lead to its development remain a matter of debate, it appears likely that BPD develops through the accumulation and interaction of multiple factors, including temperament, childhood and adolescent experiences, and other environmental factors. One common factor in people with BPD is history of traumatic events during childhood and adolescence, in particular physical, sexual and emotional abuse, neglect, hostile conflict, and early parental loss or separation. However, the association with childhood and adolescent trauma is neither ubiquitous in BPD nor unique to this personality disorder. Other psychosocial and demographic factors associated with the disorder may reflect the consequences of the disorder on the individual's life rather than causal processes. A role for genetic factors mediating the response to environmental factors and life events has been postulated, but the evidence is sparse. Neurobiological mechanisms have also been proposed on the basis of neuroimaging data, but it is unknown whether any biological dysfunction associated with BPD is a cause or consequence of the disorder.

Neuropsychological impairments associated with BPD appear to be different from other personality disorders and show specific impairments of memory and emotional processing.

- f) BPD can be a seriously disabling condition and often takes a huge toll on the individual. People with BPD usually develop signs and symptoms of the disorder in adolescence or early adulthood. They may experience difficulties such as considerable changes in mood, lack of confidence, impulsive and self-injurious behaviour, substance use, excessive sensitivity and fears of rejection and criticism. As a consequence it is hard for people with BPD to develop mature and lasting relationships or to function successfully in the home, educational settings and the workplace. Failures in these areas accentuate feelings of rejection, depressive moods and self-destructive impulses. As a result of their difficulty in controlling their impulses and emotions, and also their often distorted perceptions of themselves and others, people with BPD may experience enormous pain and evoke high levels of anxiety in those around them. Suicide is a particular risk in BPD, with up to one in 10 people with BPD committing suicide. The impact of the disorder on the individual is often exacerbated by presence of comorbid conditions such as affective disorders and substance misuse.
- g) In general, the impact of the disorder and the risk of suicide is greatest in early adulthood. The short to medium term outcome is poor, however longer term follow-up is more positive. Although most people with BPD still have significant morbidity. For example, some long-term studies of BPD indicate that only 50% of women and 25% of men diagnosed with the condition gain stability and satisfactory relationships characterised by intimacy.
- h) People with BPD use mental health services at higher rates than people from other mental health diagnostic groups, except for people with schizophrenia. They tend to make heavy demands on services, having frequent contact with mental health and social services,

accident and emergency departments, GPs and the criminal justice system, and are likely to be high-cost, persistent, and intensive users of mental health services.

- i) It should be noted that a separate guideline on Antisocial Personality Disorder (ASPD) is being developed in parallel to the development of the BPD guideline. Beyond the differences in the diagnostic criteria for BPD and ASPD, there are good grounds for developing two separate guidelines for these disorders, rather than one unified guideline on personality disorders, as there are marked differences in the populations the guidelines will address in terms of their interaction with services. People with BPD tend to be treatment seeking and at high risk of self-harm and suicide, whereas people with ASPD tend not to seek treatment, are likely to come into contact with services via the criminal justice system and their behaviour is more likely to be a risk to others. Nevertheless, it is acknowledged that people with either of these diagnoses may present with some symptoms and behaviour normally associated with the other diagnosis.

## **4 The guideline**

- a) The guideline development process is described in detail in two publications that are available from the NICE website (see 'Further information'). 'The guideline development process: an overview for stakeholders, the public and the NHS' describes how organisations can become involved in the development of a guideline. 'The guidelines manual' provides advice on the technical aspects of guideline development.
- b) This document is the scope. It defines exactly what this guideline will (and will not) examine, and what the guideline developers will consider. The scope is based on the referral from the Department of Health (see appendix).

- c) The areas that will be addressed by the guideline are described in the following sections.

## **4.1 Population**

### **4.1.1 Groups that will be covered**

- a) Adults (aged 18 years and older) with a diagnosis of BPD.
- b) People younger than 18 years with borderline symptoms, or putative borderline personality disorder.
- c) People with BPD and a learning disability.

## **4.2 Healthcare setting**

- a) The guideline will cover the care provided within primary, community, secondary and specialist health care services within the NHS. The guideline will include specifically:
- care in general practice and NHS community care
  - hospital outpatient, day and inpatient care, including secure hospitals
  - primary/secondary interface of care
  - the transition from child and adolescent services to adult services
  - care in prisons and the transition from prison health services to NHS services
- b) This is an NHS guideline. It will comment on the interface with other services such as: prison health services, forensic services, social services and the voluntary sector. It will not include recommendations relating to the services exclusively provided by these agencies; except insofar as the care provided in those institutional settings is provided by NHS healthcare professionals, funded or contracted by the NHS.

### **4.3 Clinical management**

#### **Areas that will be covered by the guideline**

- a) Early identification of borderline personality disorder: clarification and confirmation of diagnostic criteria currently in use, and therefore the diagnostic factors that trigger the use of this guideline.
- b) Treatment pathways.
- c) The full range of treatment and care normally made available by the NHS, including art and music therapy.
- d) All common psychological interventions currently employed in the NHS, including dynamic psychotherapy and cognitive behavioural treatments.
- e) The appropriate use of pharmacological interventions, including initiation and duration of treatment, management of side effects and discontinuation. Note that guideline recommendations will normally fall within licensed indications; exceptionally, and only where clearly supported by evidence, use outside a licensed indication may be recommended. The guideline will assume that prescribers will use a drug's summary of product characteristics to inform their decisions for individual patients. Nevertheless, where pharmacological interventions are commonly utilised off-licence in treatment strategies for people with BPD in the NHS, the evidence underpinning their usage will be critically evaluated.
- f) Combined pharmacological and psychological treatments.
- g) Therapeutic communities.

- h) The therapeutic environment, including team and individual professional's functioning and how they are influenced by working with this client group.
- i) Treatment of people younger than 18 years for borderline symptoms, or putative borderline personality disorder, in so far as the treatment may alter the level of impairment, risk or progression to adult borderline personality disorder.
- j) Management of common comorbidities in people with BPD, as far as these conditions affect the treatment of BPD.
- k) Management of BPD in individuals who also have a learning disability.
- l) Sensitivity to different beliefs and attitudes of different races and cultures.
- m) The role of the family or carers in the treatment and support of people with BPD (with consideration of choice, consent and help), and support that may be needed by carers themselves.
- n) The guideline development group will take reasonable steps to identify ineffective interventions and approaches to care. When robust and credible recommendations for re-positioning the intervention for optimal use, or changing the approach to care to make more efficient use of resources, can be made, they will be clearly stated. When the resources released are substantial, consideration will be given to listing such recommendations in the 'Key priorities for implementation' section of the guideline.

**Areas that will not be covered by the guideline**

- a) Treatments not normally available in the NHS.
- b) The separate management of comorbid conditions.



## **4.4 Status**

### **4.4.1 Scope**

This is the consultation draft of the scope. The consultation period is 21 November – 19 December 2006.

The guideline will cross-refer to relevant clinical guidance issued by the Institute, including:

*Schizophrenia: core interventions in the treatment and management of schizophrenia in primary and secondary care (2002);*

*Depression: the management of depression in primary and secondary care (2004); Anxiety: management of generalised anxiety disorder and panic disorder (2004);*

*Self-harm: The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary (2004);*

*Post Traumatic Stress Disorder; Management of post-traumatic stress disorder in adults in primary, secondary and community care (2005);*

*Obsessive Compulsive Disorder: Core interventions in the treatment of obsessive compulsive disorder and body dysmorphic disorder (2005);*

*Violence: The short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments (2005);*

*The treatment and management of bipolar disorder (2006);*

*Drug misuse: Opiate detoxification of drug misusers in the community and prison settings (expected publication 2007);*

*Drug misuse: Psychosocial management of drug misusers in the community and prison settings (expected publication 2007);*

*Attention deficit hyperactivity disorder: pharmacological and psychological interventions in children, young people and adults* (expected publication 2008).

*Antisocial personality disorder: treatment, management and prevention* (expected publication 2008)

#### **4.4.2 Guideline**

The development of the guideline recommendations will begin in January 2007.

## **5 Further information**

Information on the guideline development process is provided in:

- *An overview for stakeholders, the public and the NHS (2006 edition)*
- *The guidelines manual (2006 edition)*

These booklets are available as PDF files from the NICE website (<http://www.nice.org.uk/page.aspx?o=guidelinesmanual>). Information on the progress of the guideline will also be available from the website.

## **Appendix – Referral from the Department of Health**

The Department of Health asked the Institute to develop a guideline:

‘... for the evidence-based primary and secondary care treatment of adults diagnosed with borderline personality disorder and to consider which settings are most appropriate for which interventions. Where appropriate evidence related to those with learning disability should be included.’