Borderline Personality in the Medical Setting

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ABSTRACT

Objective: Individuals with borderline personality disorder in mental health settings tend to present with relationship difficulties, mood instability/dysphoria, and overt self-harm behavior. In contrast, it appears that individuals with borderline personality disorder in medical settings manifest physical symptoms that are medically difficult to substantiate. Through a review of the literature, we examine 2 symptom manifestations among patients with borderline personality in primary care and general medical settings—namely pain sensitivity and multiple somatic complaints. In addition to reviewing the research of others, we also highlight our own investigations into these 2 areas.

Data Sources: We conducted a literature search of the PubMed database and a previous version of the PsycINFO search engine (no restrictions). Search terms included *borderline personality*, *borderline personality disorder*, *personality disorders*; *chronic pain*, *pain*, *pain syndromes*; and *somatization disorder*, *Briquet's syndrome*, *somatic preoccupation*, *somatic*.

Study Selection: Published articles related to borderline personality, pain and somatic symptoms (ie, somatization disorder, somatic preoccupation) were examined.

Results: According to our review, the literature indicates higher-than-expected rates of borderline personality disorder among patients in primary care and general medical settings who present with chronic pain conditions and/or somatic preoccupation.

Conclusions: Unlike patients with borderline personality disorder in mental health settings, who tend to present with relationship difficulties, mood instability/dysphoria, and overt self-harm behavior, patients with borderline personality disorder in primary care settings tend to present with unsubstantiated chronic pain of various types as well as somatic preoccupation.

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Borderline personality disorder is a complex personality dysfunction that is characterized by a fragile but intact social veneer, longstanding self-regulation difficulties (eg, eating disorders such as anorexia or bulimia nervosa, substance misuse, sexual promiscuity), and repetitive self-destructive behavior (eg, cutting, hitting, burning oneself; suicide attempts).[1] While the latter 2 symptoms in borderline personality disorder (ie, self-regulation difficulties and self-destructive behavior) may occur with other types of psychiatric disorders, a distinguishing characteristic of individuals with this particular type of personality dysfunction is the presence of a unique interpersonal style. This interpersonal style is characterized by simultaneous emotional distancing and emotional enmeshment (unstable relatedness), dependency, manipulativeness, exquisite interpersonal sensitivity, and emotional overreactivity. According to the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (*DSM-5*), the prevalence of borderline personality disorder in the general population is between 2% and 6%, with 75% of those afflicted being female.[2] However, some researchers report community rates at 6%, with equal prevalence rates between the genders.[3] Like other psychiatric disorders, the postulated etiology of borderline personality disorder is the indistinct interaction of genetics and the environment.[2] With regard to environmental factors, a common theme in the childhood histories of individuals with borderline personality disorder is repetitive trauma (eg, physical, sexual, emotional abuses; witnessing violence).[1]

While the core psychological features of borderline personality disorder are similar among patients in both mental health and primary care settings, there appear to be some distinct differences in their clinical presentations in these respective settings.[1] Patients with borderline personality disorder in psychiatric settings tend to verbalize concerns about relationship difficulties, report mood instability/lability and dysphoria, and exhibit graphic forms of self-harm behavior (eg, cutting oneself), including suicide attempts. In contrast to mental health settings, patients with borderline personality disorder in primary care settings tend to describe unsubstantiated physical symptoms within the context of 2 distinctive patterns: (1) pain sensitivity and (2) multiple somatic complaints.

Another distinguishing feature of patients with borderline personality disorder in medical settings is the atypical expression of the traditional feature of self-harm behavior. Rather than the graphic self-harm behavior and suicide attempts observed among patients in mental health settings, self-harm behavior among patients in primary care settings may emerge as an overstated disabled lifestyle (ie, the inability to be fully functional, particularly with regard to employment). This disabled lifestyle is frequently highlighted by the patient's misperception of an inability to work, requests for and/or receipt of unnecessary handicap parking placards, and/or seeking or procuring unwarranted disability benefits. This disabled depiction is not meant to imply the absence of underlying genuine illness or physical dysfunction, but to underscore the perception by the patient of an inflated degree of impaired functionality and concomitant behaviors.

In this article, we will review the available research on the 2 predominant physical syndromes encountered among patients with borderline personality disorder in primary care settings—ie, pain sensitivity and multiple somatic complaints. In addition to reviewing the research of others, we will especially highlight our own investigations into these 2 areas.

Clinical Points

- Patients with borderline personality disorder tend to present with different symptoms as a function of treatment setting. In mental health settings, patients with this disorder tend to present with relationship difficulties, mood lability/dysphoria, and graphic self-harm behavior. In primary care settings, patients with this disorder tend to present with pain sensitivity and somatic preoccupation.
- The characteristic symptoms observed in patients with borderline personality in primary care settings (ie, pain sensitivity/syndromes, somatic preoccupation) have been described in the literature by a number of clinicians and verified by a number of investigators, including the authors.
- Clinicians in primary care settings need to modify their perceptions of patients with borderline personality—from the classic mental health presentation to the empirically confirmed primary care presentation.

METHOD

We undertook a review of the literature using the PubMed search engine as well as a previous version of the PsycINFO search engine (no restrictions). Search terms included *borderline personality*, *borderline personality disorder*, *personality disorders*; *chronic pain*, *pain*, *pain syndromes*; and *somatization disorder*, *Briquet's syndrome*, *somatic preoccupation*, *somatic*. Published articles related to borderline personality, pain, somatization, and somatic preoccupation were examined.

RESULTS

Pain Sensitivity and Borderline Personality Disorder

As early as 1990, Merceron and colleagues[4] assessed patients with psychological testing and reported an association between chronic pain and borderline personality disorder features. In 2004, Harper reaffirmed this early empirical conclusion by stating that, "it [is] particularly difficult for . . . [the borderline patient] . . . to endure prolonged acute pain"[(p196)]; "the borderline patient's tolerance of discomfort will typically be of shorter duration than other individuals."[5(p197)] Thus, clinicians have known for some time that patients with borderline personality disorder in primary care settings appear to demonstrate a poor tolerance for pain. Only recently have investigators empirically examined this relationship in any depth. In reviewing this literature, 2 distinct waves of research emerge: (1) pain sensitivity in relationship to the presence of borderline personality disorder symptoms and (2) the determination of the explicit prevalence rate of borderline personality disorder among patients with chronic pain. We will now review these 2 waves of research.

Wave 1: pain sensitivity and borderline personality disorder. In the first wave of research, which began in the mid-2000s, investigators examined the relationship between levels of perceived pain and borderline personality disorder symptoms. Paradoxically, earlier studies of patients with borderline personality disorder in mental health settings espoused an insensitivity or tolerance to pain. However, clinicians in primary care settings observed the opposite reaction among their patients—that patients with borderline personality disorder reported pain sensitivity or intolerance.[1]

To begin our review, Tragesser and colleagues[6] examined 777 participants who were in rehabilitation because of pain and found that the cohort with borderline personality disorder reported relatively greater pain severity in comparison with their peers without the disorder, including higher levels of minimum and maximum pain during the past month. Frankenburg and Zanarini[7] compared 200 participants with borderline personality disorder who were in symptom remission to 64 participants who were still evidencing active symptoms. Participants with borderline personality disorder in symptom remission reported significantly fewer pain-related conditions such as fibromyalgia, temporal-mandibular joint syndrome, and back pain.[7] McWilliams and Higgins[8] examined data from the National Comorbidity Survey Replication study and found that individuals with any of 4 types of pain syndromes (ie, arthritis, severe/frequent headaches, chronic spinal pain, other chronic pain) evidenced higher levels of borderline personality disorder symptoms than participants without these syndromes. In this study, participants with headaches evidenced the highest mean borderline personality disorder score among the various pain groups.[8]

As for our own studies on the relationship between perceived levels of pain and borderline personality disorder symptoms, in an initial investigation, we examined 80 internal medicine outpatients (74% women, 90% white) who were being seen by 2 resident clinicians.[9] In this study, we encountered statistically significant correlations in 5 of the 6 statistical analyses (2 pain scores × 3 measures of borderline personality disorder) between self-rated pain scores at present and over the past 12 months and scores on 3 self-report measures of borderline personality disorder (ie, the Personality Diagnostic Questionnaire–4, the Self-Harm Inventory, and the McLean Screening Instrument for Borderline Personality Disorder).[9]

In a second larger study,[10] we examined a cross-sectional consecutive sample of 238 internal medicine outpatients (63% women, 77% white) who were being seen in a resident physician clinic. In this study, we assessed borderline personality disorder with 2 self-report measures (ie, the Personality Diagnostic Questionnaire–4 and the Self-Harm Inventory) and inquired about pain levels "now," "over the past week," and "over the past year." Consistent with our earlier findings, participants who evidenced borderline personality disorder symptomatology on either measure reported statistically significantly higher levels of pain at the time of assessment, during the past week, and during the past year at the $P < .001$ level.[10]

In this previous study,[10] we also assessed participants for pain catastrophizing (ie, catastrophic thoughts and feelings about pain) using the Pain Catastrophizing Scale.[11] The

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Pain Catastrophizing Scale contains 3 subscales that assess contributory factors to pain catastrophizing (ie, rumination, magnification, helplessness). As anticipated, participants in this study with higher borderline personality disorder scores demonstrated statistically significantly higher scores on both the total Pain Catastrophizing Scale score and each of its 3 subscales. Frankly, we were hoping that a particular subscale of the Pain Catastrophizing Scale would crest, perhaps providing us with a distinct avenue for future intervention among these individuals. However, we found that no particular subscale of the Pain Catastrophizing Scale was pronounced, suggesting that rumination, magnification, and helplessness all equally contributed to pain catastrophizing in this cohort.

Collectively, these preceding studies indicate that individuals with borderline personality disorder (at least those with active symptoms) generally report higher levels of pain (ie, pain sensitivity) than individuals without borderline personality disorder. In addition, findings indicate that pain symptoms among individuals with borderline personality disorder are associated with pain catastrophizing, with no particular feature of pain catastrophizing being most prominent (ie, rumination, magnification, helplessness).

Wave 2: the prevalence of borderline personality disorder among pain patients. Somewhat concurrent with the first wave, a second wave of research in this area unfolded with the examination of the explicit prevalence rates of borderline personality disorder among various types of pain populations. In this regard, Gatchel and colleagues[12] examined 152 tertiary care patients with chronic low back pain and found that 26.9% met the criteria for borderline personality disorder according to the Structured Clinical Interview for *DSM* Personality Disorders. Manchikanti and colleagues[13] examined 150 tertiary care patients with chronic back pain (2 groups) and reported that 10% and 12%, respectively, met the criteria for borderline personality disorder according to the Millon Clinical Multiaxial Inventory–III. Workman and colleagues[14] examined 26 patients referred to a physical therapy pain management program and found that 31% met the criteria for borderline personality disorder according to the Personality Diagnostic Questionnaire–Revised. Dersh and colleagues[15] examined 1,323 patients with occupational spine disorders and reported that 27.9% met the criteria for borderline personality disorder according to the Structured Clinical Interview for DSM Personality Disorders. Braden and Sullivan[16] examined 1,208 individuals from a community sample and found that, among those with pain, 27.4% met the criteria for borderline personality disorder according to the International Personality Disorder Examination screening questionnaire. Fischer-Kern and colleagues[17] examined 43 patients with various types of chronic pain symptoms and reported that 58% met the criteria for borderline personality organization according to the Structured Interview of Personality Organization.

As for our own endeavors in this area, in an initial prevalence study, we examined 17 outpatients with chronic pain (71% women, 88% white) who were being seen in a family practice setting.[18] For the assessment of borderline personality disorder symptoms, we used 2 self-report measures (ie, the Personality Diagnostic Questionnaire–Revised and the Self-Harm Inventory) as well as a semistructured interview (ie, the Diagnostic Interview for Borderlines). In this study, we found that 47.1% of participants evidenced borderline personality disorder symptoms according to the Personality Diagnostic Questionnaire–Revised, 29.4% according to the Self-Harm Inventory, and 47.1% according to the Diagnostic Interview for Borderlines. Moreover, nearly 25% of this small sample exceeded the cutoff score for borderline personality disorder on 2 measures, and 18% exceeded the cutoff score for borderline personality disorder on all 3 measures.[18]

In a second prevalence study,[19] we examined the rate of borderline personality disorder symptoms among a consecutive sample of 117 chronic pain patients (62% women, 90% white) who were being seen by a pain management specialist in a private practice setting. Borderline personality disorder symptoms were assessed with 2 self-report measures (the Personality Diagnostic Questionnaire–4 and the Self-Harm Inventory). Results indicated that 9.4% met the cutoff score for borderline personality disorder on the Personality Diagnostic Questionnaire–4, whereas 14.5% met the cutoff score for borderline personality disorder on the Self-Harm Inventory. The relatively lower rates of borderline personality disorder encountered in this sample compared to our initial sample may be explained by the relatively higher rate of private insurance among participants (ie, private insurance is generally reflective of higher functioning individuals). Regardless, prevalence rates for borderline personality disorder remained higher than rates encountered in community samples.[19]

When averaged, the prevalence rate of borderline personality disorder and/or symptoms in the preceding 8 studies of pain in medical settings is 30.0% (ie, nearly one-third). Moreover, all of the preceding second-wave studies support the same conclusion: cohorts with various types of chronic pain demonstrate higher-than-expected associations with borderline personality disorder. In summarizing both waves of research in this area, we can draw 2 interrelated conclusions: (1) patients with borderline personality disorder tend to be sensitive to or overexperience pain, and, therefore, (2) borderline personality disorder is overrepresented in various types of pain populations.

Quagmires for clinicians. Given the empirically confirmed amplification of pain symptoms among individuals with borderline personality disorder (ie, pain catastrophizing),[10] clinicians may find themselves in a unique clinical bind. To begin, the Joint Commission for the Accreditation of Hospitals introduced specific pain management standards for its constituents on January 1, 2001.[20] (The Joint Commission accredits and certifies more than 19,000 health care organizations and programs in the United States and, therefore, influences a significant proportion of physicians and other prescribers and their practice styles.[21]) The standards announced by the Joint Commission actively promoted to treatment providers and

organizations the right of patients to appropriate assessment and management of pain. This standard required routine screening of patients for pain symptoms in "ambulatory care facilities, behavioral health care organizations, critical access hospitals, home care providers, hospitals, office-based surgical practices, and long term care providers," as well as the requirement that "appropriate [pain] care should be made available."[20]

Faced with habitually soliciting and treating pain symptoms of patients, clinicians encounter a unique dilemma among those with borderline personality disorder. As we have demonstrated, the empirical data indicate that a meaningful proportion of patients with borderline personality disorder overexperience pain. As a result, the clinician is straddled with the complex task of *accurate* pain assessment. To complicate matters, the common clinical approach to the assessment of pain in primary care settings is the use of a visual analog scale. Using this self-report method, patients are asked to estimate along a range of graded responses the severity of their pain (ie, the pain assessment is entirely subjective). While a subjective approach may be reasonable in the assessment of pain in the patient without borderline personality disorder, the patient with the disorder tends to be pain sensitive and to overendorse pain severity, thereby risking the prescription of analgesic treatment that exceeds his/her genuine level of pain. In addition, inquiring about pain during each office visit reinforces the importance of this particular symptom and may serve to unintentionally reinforce dysfunctional pain behaviors.

In our opinion, it is not possible to accurately determine pain levels among patients with borderline personality disorder on the basis of self-report assessment. Therefore, it is challenging to prescribe an appropriate pain management regimen. Unfortunately, at the present time, there are no practical alternatives for objectively measuring pain in primary care settings.

In addition to the inherent difficulties with the assessment of pain in patients with borderline personality disorder, the prescription of analgesics for these individuals is complicated by their high rates of substance misuse. In a review of the literature, we encountered 4 studies that denoted lifetime prevalence rates for substance misuse in patients with borderline personality disorder,[22] which when averaged was 64%. Stated another way, nearly two-thirds of patients with borderline personality disorder have had substantial substance misuse problems at some point during their lifetimes. According to Dhossche and Shevitz,[23] the preferred substances of misuse by the personality disordered in medical settings are benzodiazepines, opiates, and stimulants.

Multiple Somatic Symptoms and Borderline Personality Disorder

In addition to pain sensitivity, a second common clinical presentation among patients with borderline personality disorder who seek treatment in primary care and general medical settings is multiple somatic symptoms. We now review the literature in this area, including our own work.

Historical perspectives. At the outset, a number of authors have observed and described multiple somatic symptoms among patients with borderline personality disorder. Schreter[24] reported a relationship between borderline personality disorder and chronic somatic symptoms among participants in group psychotherapy. Giovacchini[25,26] described a subset of patients with borderline personality disorder and psychosomatic preoccupation. Bernstein[27] proposed that somatic symptoms may mask an underlying borderline personality disorder. Hull and colleagues[28] described a patient with borderline personality disorder whose acting-out behaviors were synchronized with exacerbations of physical illness. Finally, Janssen[29] reported 2 clinical cases in which patients with borderline personality disorder presented with somatic symptoms. These enticing historical accounts heralded the need for systematic research into the relationship between borderline personality disorder and multiple somatic complaints.

Early studies: borderline personality disorder and somatization disorder. Early investigations in this area focused on the relationship between borderline personality disorder and somatization disorder. Somatization disorder, a diagnostic construct in previous versions of the *DSM*, is characterized by multiple somatic symptoms in 4 distinct symptom categories. As for the findings of these studies, Prasad and colleagues,[30] Hudziak and colleagues,[31] and Spitzer and Barnow[32] confirmed distinct relationships between somatoform disorders and borderline personality disorder. However, given the restrictive clinical nature of somatization disorder (ie, multiple symptoms in 4 distinct categories), there was a genuine need to examine somatic characteristics from a more clinically relevant perspective (ie, that of somatic preoccupation).

Borderline personality disorder and somatic preoccupation. A number of studies have investigated and verified clinical relationships between borderline personality disorder and somatic preoccupation in the primary care setting. In an early investigation, Lloyd and colleagues[33] found a relationship between borderline personality disorder, as assessed with the Minnesota Multiphasic Personality Inventory, and a proneness to reporting somatic complaints.

As for our own investigations, in an initial study,[34] we examined relationships between borderline personality disorder and somatic preoccupation among 118 internal medicine outpatients (72% women, 92% white) in a resident physician clinic. We assessed borderline personality disorder symptoms with 2 self-report measures (the Personality Diagnostic Questionnaire–Revised and the Self-Harm Inventory) and assessed somatic preoccupation with the Bradford Somatic Inventory. We confirmed relationships between borderline personality disorder on both measures and 3 medically self-harming behaviors (ie, preventing wounds from healing, making medical situations worse on purpose, abusing prescription medication). We then examined the relationship between these 3 self-harming behaviors (all related to borderline personality disorder

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symptoms) and somatic preoccupation and found a moderate statistical correlation.[34]

In a second study, among 120 internal medicine outpatients (72% women, 91% white) in a resident physician clinic, we examined the relationship between borderline personality disorder symptoms, as measured by the Personality Diagnostic Questionnaire–Revised, and somatic preoccupation, as measured by the Bradford Somatic Inventory.[35] Using a simple correlational analysis, we confirmed among these outpatients a relationship between borderline personality disorder symptomatology and somatic preoccupation ($r = 0.43$, $P < .01$).

In a third sample of 116 internal medicine outpatients (67% women, 84% white) in a resident physician clinic, we examined borderline personality disorder symptoms with the Personality Diagnostic Questionnaire–4 and the Self-Harm Inventory and somatic preoccupation with the Bradford Somatic Inventory.[36] In this study, we found that both borderline personality disorder measures demonstrated statistically significant correlations, with the measure of somatic preoccupation in the moderate-to-high range (Personality Diagnostic Questionnaire–4, $r = 0.58$, $P < .001$; Self-Harm Inventory, $r = 0.53$, $P < .001$).

Lastly, we undertook a study of this phenomenon using a different somatic measure.[37] To explain our reasoning, we were concerned that the Bradford Somatic Inventory might be measuring a particular, distinct, and/or limiting aspect of somatic preoccupation. So, to reexamine somatic preoccupation from an entirely different perspective, we obtained a list of 35 symptoms that constituted a medical review of systems. Using an author-developed adaptation, the items were preceded by the phrase, "Have you experienced any of the following symptoms in the past week," with yes/no response options. Then, in a cross-sectional sample of 381 internal medicine outpatients (65% women, 88% white) in a resident physician clinic, we assessed the number of symptoms endorsed in relationship to 2 self-report measures for borderline personality disorder symptoms (ie, the Personality Diagnostic Questionnaire–4 and the Self-Harm Inventory). As anticipated, we found that the total number of symptoms endorsed on the medical review of systems positively correlated with both measures of borderline personality disorder symptomatology (Personality Diagnostic Questionnaire–4, $r = 0.42$, $P < .001$; Self-Harm Inventory, $r = 0.36$, $P < .001$).[37]

In this final study,[37] we also examined whether or not there were any particular symptom patterns associated with borderline personality disorder. However, no individual symptom or symptom pattern was evident among the borderline personality disorder subsample. In other words, participants with borderline personality disorder evidenced somatic symptoms that were panoramic and diverse.

CONCLUSIONS

Patients with borderline personality disorder are characterized by 3 clinical features: (1) a fragile but intact social veneer, (2) chronic self-regulation difficulties, and (3) self-destructive behavior. While patients with borderline personality disorder in mental health and primary care settings display similar psychologies, their symptoms appear to differ somewhat. In mental health settings, patients with borderline personality disorder demonstrate dysfunctional interpersonal relationships, mood lability/dysphoria, and graphic self-harm behavior. In contrast, patients with borderline personality disorder in primary care settings tend to present with unsubstantiated symptoms that anchor around excessive pain sensitivity (pain syndromes) and somatic preoccupation. These latter syndromes have been verified by a number of published observations by clinicians as well as empirical endeavors in the literature. The next step in this process is to develop effective treatment strategies for patients with borderline personality disorder in primary care settings who present with pain sensitivity and/or somatic preoccupation. This will truly be a challenging undertaking. Such an endeavor will most likely incorporate manualized approaches based on the cognitive restructuring of symptom interpretation—provided within the shelter of the primary care setting. The future offers promise.

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