People with borderline personality disorder may benefit from a guided formulation approach to care. It can help them to understand and manage their condition.

Management of borderline personality disorder

In this article...

- Explanation of personality disorder diagnosis
- Current and past treatment for BPD
- How guided formulation can help people with BPD

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This article gives an overview of personality disorders, with a focus on borderline personality disorder. It also describes the setting up of a trust-wide service to treat people with BPD, led by mental health workers and using guided formulation. The role of guided formulation in the management of BPD is explored. It is suggested that this form of treatment can greatly improve outcomes for patients.

People learn to recognise personal differences and to predict how others are likely to behave in certain situations; we learn how to respond to others to get the best out of them and ourselves. In our minds, we establish a wide spectrum of behaviour. Society also creates such a spectrum. Some people display such extreme behaviour that they are regarded as being outside this spectrum. These people are often described as having a personality disorder.

The International Classification of Mental and Behavioural Disorders (ICD-10), defines a personality disorder as “a severe disturbance in the characterological condition and behavioural tendencies of the individual, usually involving several areas of the personality, and nearly always associated with considerable personal and social disruption” (World Health Organization, 1992). A more straightforward description is that of personality disorder cluster groups (American Psychiatric Association, 1994) (Table 1).

Despite being less well known than schizophrenia or bipolar disorder, personality disorders are more prevalent, affecting 1–2% of adults (Gibson, 2006). In mental health, people diagnosed with borderline personality disorder (BPD) make up 50% of inpatients and 40% of people receiving community services (National Institute for Mental Health in England, 2003). Women are more likely to be diagnosed with BPD and men more likely to be diagnosed with an antisocial personality disorder. People from ethnic minorities are less likely to attract a BPD diagnosis (Gibson, 2006).

Also known as emotionally unstable personality disorder, BPD is the most common personality disorder. The term borderline was coined by Adolph Stern in 1938 to describe people on a “borderline” between neurosis and psychosis. However, the symptoms are not as simple as this implies. Diagnosis is based on emotional instability, feelings of emptiness, and behavioural and identity disturbance (Jorgensen, 2010), as well as neurosis and psychosis.


Persons with BPD often have other mental health problems such as anxiety, depression and substance misuse, generally due to attempts at finding ways to manage emotional distress (Grant et al, 2004). The following symptoms may also be present.

5 key points

1. Borderline personality disorder, also known as emotionally unstable personality disorder, is the most common personality disorder.
2. People with BPD often have highly unstable social relationships and their mood and feelings can fluctuate greatly.
3. Emotional events can trigger the onset of BPD.
4. Guided formulation can help clients to “make sense” of their experiences, feelings, relationships and behaviour.
5. Guided formulation can provide the basis for a consistent and cohesive care plan.

Guided formulation includes agreeing a written structure for discussions.
Because they are impulsive, people with BPD often have highly unstable relationships. While they can develop intense attachments, their attitude can suddenly shift from great admiration to intense anger and dislike. They are highly sensitive to rejection, reacting with anger and distress to what others may regard as common occurrences. With staff, these occurrences can include shift changes, sickness, holiday or a sudden change in plans, which can leave people with BPD feeling lost and worthless. Along with expressions of anger, this can result in the patient threatening or even attempting suicide (National Institute for Mental Health, 2009).

**Causes of BPD**

Although a specific cause is unknown, environmental and genetic factors are thought to be involved (National Institute for Mental Health, 2009). Childhood experiences of verbal, sexual or emotional abuse, neglect of age-appropriate physical needs, parental illness or prolonged early separations and chaotic and dysfunctional situations are all thought to make BDP feel lost and worthless. Along with expressions of anger, this can result in the patient threatening or even attempting suicide (National Institute for Mental Health, 2009).

**History of treatment**

Over the past 30 years, there has been a dramatic change in views on treatment of BPD (Gibson, 2006). In the 1970s, long-term psychoanalytic psychotherapy and psychodynamic psychotherapy were the treatments of choice (Gibson, 2006). However, in the 1980s, these were seen as unsuccessful and medication became the standard treatment (Gibson, 2006).

In the 1990s, group and family therapy emerged as potentially useful. Dialectical behaviour therapy had the most significant effects (Linehan, 1993), but research has since shown its effectiveness to be limited (Verheul et al, 2002).
In 1999, psychiatrist Anthony Bateman and psychologist Peter Fonagy pioneered mentalisation. Mentalisation is recognising what is going on in the mind. This therapy is intended to help people to improve their ability to mentalise and be willing to use this ability, especially when feeling intense emotions. The therapist might ask a patient to consider what a person in a difficult situation might have been thinking, then help the patient to go beyond their initial assumption, especially if this is negative.

Increasing the ability to mentalise significantly improves a variety of areas, including deliberate self-harm, suicidal behaviour, anxiety and depression (Gibson, 2006). If a person with BPD is planning to take an overdose, their thought processes tend to confirm this is the “right” thing to do. They can use mentalisation to look at their thinking and analyse whether their thoughts and feelings about the overdose are caused by feelings of negativity; this helps them to come to the decision to hold off the decision until they feel more settled.

Guided formulation
Guided formulation was developed by Somerset Partnerships Foundation Trust’s personality disorder service. It forms the core of the care pathway for personality disorders in Somerset.

Guided formulation is a psychologically minded process shared by a patient and a specially trained mental health professional over about 6-8 weeks. The process includes writing a concise, jointly agreed summary document, under the guidance of a clinical supervisor (the guide). This helps to consider what a person in a difficult situation might be thinking and feeling about the overdose. It provides a basis for a consistent and cohesive care plan.

**The role of the guide**
The “guide” is usually a specially trained clinical supervisor in the personality disorder service or other trained clinical supervisor. It is essential that they are not directly involved with the patient due to psychological and relational issues that arise in a treatment relationship.

**Practicalities and anxieties**
The approach needs to be discussed and agreed with the patient and regular meetings arranged. It is important to agree a venue where the patient feels comfortable talking about distressing issues and where privacy and confidentiality can be maintained. New interventions can cause anxieties that should be addressed from the start.

People with BPD often have a distorted or limited capacity to self-reflect and can be impulsive, so a risk management and crisis plan is only effective if it is agreed as part of a working relationship. Guided formulation can help people to reflect, make sense of risk and to identify protective factors.

**Conclusion**
By facilitating relationships, reflection and understanding through guided formulation, frontline mental health workers can help people with BPD address difficulties, maximise strengths and take steps towards recovery with the ultimate aim of discharge from mental health services.

**References**


