Effective Healthcare Strategies for Patients with Borderline Personality Disorder

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Objectives

- Provide an overview of the diagnostic criteria and interpersonal presentation of the patient with borderline personality disorder
- Enhance provider's understanding of the proposed etiology of borderline personality disorder
- Review interpersonal and practical strategies to work effectively with these patients
- Discuss effective treatments for borderline personality and referral resources

DSM-V Criteria for Borderline Personality Disorder

- A pervasive pattern of instability of interpersonal relationships, self-image, affect, and marked impulsivity beginning by early adulthood and present across contexts, as indicated by five or more of these:
  - Frantic efforts to avoid real or imagined abandonment
  - A pattern of unstable and insecure interpersonal relationships alternating between extremes of idealization and devaluation
  - Identity disturbance
  - Impulsivity in at least to areas that are potentially self-damaging
  - Recurrent suicidal behavior, gestures, threats, or self-mutilation
  - Affective instability due to marked mood reactivity
  - Chronic feelings of emptiness
  - Inappropriate, intense anger or difficulty controlling anger
  - Transient, stress-related paranoid ideation or dissociative symptoms

BPD is **not**

- All suicidal patients
- All patients that you dislike
- All difficult or help rejecting patients
- All somaticizing patients

Prevalence

- 1-2% community rates
- 6% in family practice
- Much higher in outpatient and inpatient mental health settings
- ½ of BPD patients received no mental health treatment in the prior year and 42% not recognized as having a mental health disorder

Widiger TA, Weissman MM. Epidemiology of borderline personality disorder. Hosp Community Psychiatry 1991;42:1015–21 [PubMed]
Gross R, Olfson M, Gameroff M, et al. Borderline personality disorder in primary care. Arch Intern Med2002;162:53–60 [PubMed]

Common Comorbid Issues

- Bipolar, MDD most common co-occurring mood issues (31%, 32%)
- Phobia, GAD, PTSD most common anxiety-based disorders (37%, 35%, 39%)
- Associated with high rates of physical and mental disability

Grant BF, Chou SP, Goldstein RB, et al. Prevalence, Correlates, Disability, and Comorbidity of DSM-IV Borderline Personality Disorder: Results from the Wave 2 National Epidemiologic Survey on Alcohol and Related Conditions. *The Journal of clinical psychiatry*. 2008;69(4):533-545.

The case of Suzette

- Suzette, a 24 year old Caucasian woman, presents for an initial outpatient primary care visit.
- CC: Recurrent headaches
- HPI: Uncertain when headaches began; dissatisfying experience with prior PCP. Reports significant disruption in her life related to headaches
- Prior Medical History: depression; anxiety; lower back pain; inconsistent menstrual cycle
- After your initial visit, Suzette thanks you profusely, saying you're the first provider who really 'gets' her

Interpersonal Dynamics

- Splitting
  - Internal conflict between good/bad projected onto others; may lead to division within the treatment team
- Abandonment fears
  - Can lead to acting out behaviors when provider is perceived as absent or rejecting
- Hypersensitivity to feedback
  - Can lead to over-cautiousness toward the patient, excessive diagnostic testing, fears of sharing recommendations
- Simultaneous help-seeking and help-rejecting
  - Can lead to frustration and confusion on the part of the provider

Suzette returns

- Suzette returns one month later for a follow up visit
- She does not address the headaches; instead, she is in emotional distress and describes problems in her relationship with her psychiatrist. She is requesting that you take over her anti-anxiety medication. Her thinking is characterized by extremes and she seems overwhelmed by her emotions. When you attempt to discuss referral back to her psychiatrist, she angrily accuses you of being complicit with the psychiatrist.
- After your visit, Suzette calls several times per week with vague questions and requests. She also sends an apology note about your recent visit.

Etiology of Borderline Personality

- Multifactorial
  - Biologically sensitive temperament
    - Genetic factors
    - Neurobiological dysfunction
  - Early caregiving experiences
    - Invalidating environment/inappropriate modeling of emotional expression
    - Interactions discourage negative emotional arousal
    - Lack of fit between parent/child

Crowell SE, Beauchaine TP, Linehan MM. A biosocial developmental model of borderline personality: elaborating and extending Linehan's theory. *Psychol Bull.* 2009;135(3):495-510.

Etiology of BPD

- Parental psychopathology
  - Impulse control disorders and mood disorders
- Experiences of abuse/neglect
  - Very common but neither necessary nor sufficient for diagnosis

Crowell SE, Beauchaine TP, Linehan MM. A biosocial developmental model of borderline personality: elaborating and extending Linehan's theory. *Psychol Bull.* 2009;135(3):495-510.

Working Effectively with BPD patients

- Dialectical behavior therapy provides a framework for working with BPD patients
  - Acceptance of the patient (non-judgment) while maintaining appropriate limits and promoting change

Linehan MM. *Cognitive-Behavioral Treatment of Borderline Personality Disorder*. New York, NY: The Guilford Press; 1993.

Interpersonal Strategies

- Warm, supportive, non-judgmental
- Validate emotional experience
- Empathic listening
- Provide reassuring structure and routine

Linehan MM. *Cognitive-Behavioral Treatment of Borderline Personality Disorder*. New York, NY: The Guilford Press; 1993.

Communication Strategies

- Distortions are common; can be reduced by avoiding jargon and checking for understanding
- Modify unrealistic expectations about provider's ability to solve problems
- Name emotions and reflect patient's feeling
- Summarize the patient's concerns; offer frequent reflections of patient's viewpoint to clarify

Haas, L. J., Leiser, J. P., Magill, M. K., & Sanyer, O. N. (2005). Management of the difficult patient. *Am Fam Physician*, *72*(10), 2063-8.

Boundary Setting

- Clearly communicate and enforce your personal limits
- Be aware of your emotional reaction to the patient (anger, over-protectiveness)
- Be alert to deviations from your usual way of practicing (long appointments, after hours calls, etc)
- Suicidal statements will be taken seriously
- Avoid creating reinforcements of unwanted behavior

Linehan MM. *Cognitive-Behavioral Treatment of Borderline Personality Disorder*. New York, NY: The Guilford Press; 1993.

American Psychiatric Association. (2001). *Practice guideline for the treatment of patients with borderline personality disorder*. American Psychiatric Pub.

Coordinated Care

- For significant BPD, coordinated care is essential
- Get releases early in treatment for other providers
- During physical exams and especially pelvic exams, consider having another provider present

Risk Management

- Assess suicidal risk directly
  - Address patient's tendency to use vague language in an empathic way
  - "You say you may not see me at the next appointment—what do you mean?"
- Consider using an empirically supported model to guide clinical decision making (e.g., the Collaborative Assessment and Management of Suicidality)
- Distinguish between suicidal behaviors and non-suicidal self-injury
- Increase level of care based on suicidal risk (e.g., referral to outpatient therapy/psychiatry; intensive outpatient; or inpatient treatment)

Jobes, D. A. (2012). The Collaborative Assessment and Management of Suicidality (CAMS): an evolving evidence-based clinical approach to suicidal risk. *Suicide and Life-Threatening Behavior*, *42*(6), 640-653.

Making a referral

- Use patient's frame for understanding problems when making recommendations
- Instill hope for improvement
- If possible, make a referral to a specific provider

I'm aware of how much you've been suffering and I want you to know that there are options that can help. Can we spend time today talking about some ways of getting you additional support? I want to continue to be here for you, too, and will work closely with everyone on your team to make sure you are getting good care.

Suzette

Effective Treatments

- Dialectical Behavior Therapy
  - Individual therapy weekly
  - Weekly skills-based therapy group
  - Medication management
- Psychodynamic therapies
- Therapy is considered primary treatment; may adjunct with symptom-focused pharmacotherapy

American Psychiatric Association. (2001). *Practice guideline for the treatment of patients with borderline personality disorder*. American Psychiatric Pub.

Referral Options

- Akron General runs a DBT program out of Montrose location
  - 330.344.1559
- Urgent Behavioral Evaluation Team
  - 330.344.1559
- Portage Path Behavioral Health has a modified group/individual treatment
  - 330.253.3100
- Emily Program
  - 888.364.5977

Questions?