GENERAL PRACTICE south

BORDERLINE PERSONALITY DISORDER

A Resource Booklet For GPs

THE GPs MAIN TASKS WITH PEOPLE WITH BPD – 10 STEPS

Borderline Personality Disorder (BPD) is a complex and serious condition and is difficult to manage for everyone involved, including, obviously, the person with the condition. Having a structured approach to managing it can help significantly.

The key steps for the GP are:

1. Make the diagnosis
2. Understand the contemporary thinking about the condition
3. Understand the treatment approaches
4. Decide on the role you plan to have in ongoing management
5. Develop a care plan
6. Manage crisis presentations consistently
7. Manage suicidality specifically
8. Be aware of the limitations of hospitalisation
9. Be aware of the limitations of medication
10. Take care of yourself

Appendix 1: Options for advice and support

1. MAKE THE DIAGNOSIS

The main task for the GP is to consider and make the diagnosis. This is sometimes easy and sometimes difficult. In the past many health professionals have been reluctant to make the diagnosis because of the attitudes and responses the label engenders. However, we now know that if a person is diagnosed and treatment commenced by their late teens, the prognosis is much, much better than if this is delayed until their mid twenties.

DSM IV Diagnostic Criteria (American Psychiatric Association)

A pervasive pattern of instability of interpersonal relationships, self-image and affects, and marked impulsivity, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following nine criterion:

1. Frantic efforts to avoid real or imagined abandonment (*often stay in difficult, destructive or violent relationships).*
2. A pattern of unstable and intense interpersonal relationships characterised by alternating between extremes of idealisation and devaluation *(especially with health professionals).*
3. Identity disturbance: markedly and persistently unstable self-image or sense of self *(they don't know who they are and it changes with who they are with).*
4. Impulsivity in at least two areas that are potentially self-damaging e.g. spending, sex, substance abuse, reckless driving, binge eating.
5. Recurrent suicidal behaviour, gestures, threats, or self-mutilating behaviour *(pose a particular difficulty for health professionals to deal with).*
6. Affective instability due to a marked reactivity of mood e.g. intense episodic dysphoria, irritability or anxiety usually lasting a few hours and only rarely more than a few days *(can look like depression or rapid cycling bipolar disorder if taken on face value).*
7. Chronic feelings of emptiness.
8. Inappropriate, intense anger or difficulty controlling anger e.g. frequent displays of temper *(can raise child protection concerns),* constant anger, recurrent physical fights (*usually women living on the edge*).
9. Transient, stress-related paranoid ideation or severe dissociative symptoms (*often leads to misdiagnosis of schizophrenia – might be pseudo-psychotic experiences like hearing voices of the devil saying the person is evil – but the character of the symptoms is usually different to those of schizophrenia).*

What you are looking for is a longitudinal pattern of how the individual behaves in emotional situations - whether they can act in a way that is not mood dependent. All of us under extreme pressure may show some of the "borderline" qualities occasionally (eg retail therapy, losing our temper inappropriately) and most adolescents will often show these types of responses in difficult situations (eg the devastation of the loss of their first love) as part of the maturation process - usually they grow out of it. For individuals with a BPD, apparent competence in living will disintegrate under comparatively minor stress and reveal a fragile, helpless and hopeless shadow.

Common presentations to the GP can include:

- Dramatic or unusual expressions of distress (*Could be a mismatch between displayed emotion and expected emotion given the circumstances*).
- Emotional extremes with moods that shift rapidly when circumstances change.
- Suicidal ideation.
- Self harm, especially cutting, burning and overdosing.
- Self-destructive behaviours including substance abuse, disordered eating and exacerbation of gambling problems.
- Abnormal illness behaviour.

They are prone to regression, with childish behaviours and expectations under stress. They will often use primitive defences such as splitting, where the self and others are viewed as either 'all good' or 'all bad'. Their thought patterns are such that they view the external world as unsafe, others as untrustworthy and themselves as bad and unlovable. They experience major difficulty with separation and abandonment, with patterns of checking for proximity, pleading for attention, clinging behaviours and an intolerance of being alone – which makes night-time particularly problematic for this group.

Any of these presentations should alert you to look closer at the possibility of an underlying BPD and assess against the formal criteria.

2. UNDERSTAND THE CONTEMPORARY THINKING ABOUT THE CONDITION

Our personality is the sum of our personality traits which are enduring patterns of perceiving, relating to and thinking about the environment and ourselves, and which are exhibited in a wide range of important social and personal contexts. Our personality traits describe the way we adapt to our world. When the personality traits are inflexible and maladaptive and cause the individual significant functional impairment or subjective distress, that individual can be said to have a Personality Disorder.

BPD has been closely linked with a history of childhood trauma – most have suffered pre-adolescent physical, emotional and/or sexual abuse; often perpetrated by someone close to them and who they trusted. For many, the coping with the trauma results in an arrest in the acquisition of normal emotional development, followed by idiosyncratic, often inappropriate, problem solving strategies in emotional situations. An individual with BPD can be viewed, therefore, as someone whose environment did not afford them the normal opportunities to learn to live adaptively within our society. In extreme circumstances such as prolonged childhood sexual abuse, where secrecy was paramount, some individuals who later present with BPD were deliberately taught the wrong things about their emotions and how to cope by the perpetrator; the lack of knowledge about the situation by other adults prevented corrective emotional training.

What is known about the likely cause is that there seems to be a combination of:

1. **Biological irregularity** resulting in an oversensitive, over-reactive emotional response system and problems with attention control. Causative factors are often indefinable but could be associated with trauma, inadequate parent/infant interactions or genetic components. Physically this group react to emotional stimuli more quickly and strongly, and are slower to return to baseline than normal individuals.

2. **An invalidating environment.** Childhood abuse is the most extreme invalidating environment but the effects of an environment where a child's natural responses are pervasively rejected as invalid should never be underestimated. For example, when they say, "I'm sad", they might be dismissed and told, "No you're not". Their environment doesn't teach them to label or express emotions in a 'normal' manner and this results in them getting many emotions, including anger, depression, pleasure and sadness, confused.

3. **Problems in regulating emotions**. In addition to a highly reactive emotional response system, individuals with a BPD have an inability to modulate the resulting strong emotions and action. That is, they can't soothe themselves. They are often unable to inhibit inappropriate behaviour related to strong negative or positive emotions, or to refocus attention in the presence of strong emotion. It is important to remember that both extreme excitement and extreme fear can feel the same to them and can trigger such reactions.

The high reactivity of the arousal system and the individual's inability to modulate their emotions causes the difficulties in interpersonal relationships, self-image and control of thoughts, impulses and behaviours that are characteristic of BPD.

The most difficult manifestations of their distress are expressed through self harm and suicidal behaviours. They might do this to feel heard, to communicate the intensity of their distress, to elicit behaviours from others which will decrease their pain or distress and to express anger to others. The internal process that results in self harm arises from their need to: gain control over their inner experiences; replace an emotional pain with a physical one; make the emotion tangible and concrete; maintain a sense of integration so they can feel alive, centred and grounded and not 'falling to pieces'; express anger towards themself and punish themself; and express hate towards their body.

Self harm and suicidal behaviours are serious problems for the GP and others involved but are not actually problems for the person with BPD. In their worlds, they are solutions to the pain and distress they are experiencing. You have to work out what the real problem is, rather than try and treat what is, in effect, a 'solution'.

It is sometimes assumed that their behavioural expression is an expression of their feelings, however this is not necessarily so. They actually have not learned to adequately express or meet their needs. It is a learned pattern of behaviour and so it can be changed with the right therapeutic interventions.

3. UNDERSTAND THE TREATMENT APPROACHES

BPD should be thought of as a chronic condition with acute episodes from time to time. Where you start depends on where the patient is at. The priorities are safety and containment, helping them start on the journey to improvement and healing, and then supporting them as they make their way.

The GP's task on presentation is to understand and contain the emotional distress, then refer the person to the sort of help they need. The essence of the therapeutic approach to people with BPD consists of interventions that are a careful balance of:

- **Validation**: Support and understanding. Validation is more than "I hear you". It is truly understanding what is happening for the individual and how they got to where they are now. Your role is as the naïve, empathic inquisitor; and
- **Change Message**: Your role is as teacher, coach and cheerleader. "While I understand why you do what you do, we have to work on new ways of coping."

The balanced approach is crucial. If it is validation only, the person becomes bored, stuck, frustrated and still in pain. If it is the change message only, they become resistant, resentful and rebellious.

There are three common ways in which health workers tend to respond to people with BPD. An outline of these follows, along with advice on what is most helpful.

1. Enmeshed

Features of this include being over-involved, identification with the 'victim dimension', attempts to 'rescue' and 'save', going beyond the boundaries of the practice, aligning with the patient against other agencies and their boundaries, and solving problems for them. This results in reinforcing their helplessness and distress and encourages dependency. It is not in the long-term best interests of the patient.

2. Withholding

Features of this include punitive approaches and identification with the 'perpetrator' dimension. This connects with verbal and other abuse of the patient. It assumes that they are creating too many problems for the health professional and other services, and services are withdrawn without identifying boundaries and assisting patients in staying within them.

3. Nurturing and Limit-Setting

This is the most constructive response style and includes: taking care <u>for</u> the patient (not <u>of</u> them); validating their distress; recognising their ability to learn and change; teaching, coaching, assisting, strengthening, and aiding them to help themselves; recognising their existing capacities and reinforcing adaptive behaviour and self-control. There is refusal to take care of them when they can do it themselves; clear identification of the boundaries of the professional relationship; specification of unacceptable behaviours and the consequences for the patient of breaching those boundaries, including enforcing boundaries when necessary; and assisting them to manage their distress and stay within the boundaries.

In a nurturing and limit-setting framework, new ways of coping can be learned through multi-modal whole person treatment which includes appropriate diagnosis, psycho-education, psychotherapy (individual and/or group), teaching new skills including problem solving, nutrition and exercise, specialised help for substance abuse and eating disorders, and so on.

The outcome being sought through this approach is to put in what society couldn't give them when they were younger: a knowledge and understanding of their emotions and the capacity to manage them with comfort.

In summary, the healing tasks are:

1. Stabilisation – psycho-education, development of a therapeutic relationship, safety, symptom stabilisation and skill development. *(GPs can have a key role in this).*

2. Systematic and titrated uncovering of trauma. *(This involves sophisticated therapy, provided by experts only, as the risk of retraumatisation and/or exacerbation of symptoms is high*).

3. Reconsolidation and reconnection. *(Time and opportunity to integrate 1 and 2*).

Sometimes stabilisation measures are enough for the individual to reconcile the trauma on their own and sometimes not. They will know if they need to address past issues to move towards a healthy and more complete emotional life.

Whatever the approach, it must be realistic for the individual. Ultimately, the patient must drive the goals, set their own priorities and want to do the work. To be able to do this they need help in understanding what the foundations of their difficulties are. The goals are not, in the first instance, about big picture issues such as "I want a job", or "I want to be happy". They need to be about "I want to understand how I react and want to change this for the future". Setting modest goals means success can be experienced. Success, no matter how small, can be found if you look hard enough.

If a person commences treatment when they are 16 or 17, it may take only a few months to make significant progress. If they are in their twenties when they start, it can take years.

4. DECIDE ON THE ROLE YOU PLAN TO HAVE IN ONGOING MANAGEMENT

Whatever your role in treatment is, it is very important that you are consistent in your approach and set up clear expectations and boundaries with the patient.

- You may want to have a very distant role, having referred the person to a psychiatrist or psychologist to treat them.

- You may want to take the primary role in therapy i.e. providing education, skill development support and possibly even therapeutic counselling.

- Or you may want a role somewhere between the two where you are working collaboratively with a skilled clinician and other providers, where you have a specific and clearly defined role in following through on education, skill development support and so on.

Only take on what you believe is professionally and emotionally safe for you. This might vary for different people. Stick with what is comfortable for you and extend your role only as you see fit.

An important question to consider is whether you should be treating people with BPD. If you are going to be engaging them in psychotherapy be very careful, as this group of patients is particularly complex and challenging. Without specific training and ongoing supervision you could be putting yourself at increased professional risk.

5. DEVELOP A CARE PLAN

While the patient is in the more stable 'chronic' state, develop a care plan, or collaborate with other health professionals in the development of one. You can then discuss and agree on approaches for managing acute crisis presentations.

The plan is an important tool to promote a consistent and forward looking approach to management by all people involved in the therapy, including the patient. People with BPD tend to have blurred boundaries and the structure of a plan can give them, and you, helpful boundaries and an increasing sense of appropriate control. (*Krawitz & Watson have good examples of management plans – see Further Reading on page 12 for reference details).*

6. MANAGE CRISIS PRESENTATIONS CONSISTENTLY

Patients will often present to GPs in a crisis, highly distressed about, for example, a situation, themselves, a child or other family member. They may have harmed themselves (e.g. cutting or poisoning) or report being seriously depressed or suicidal.

It is important to acknowledge how distressed they are without rewarding the behaviour. There is often a chain of reactions in response to a prompting event. Commonly something happens which they respond to and think about in a specific way, and from that point they quickly move into a highly anxious or aroused state. They then tend to misinterpret that emotion, make a generalised statement about themselves, as a result have a bigger reaction, the aroused state increases further, and so on.

If they are in this state at presentation to you, try this approach:

1. Acknowledge that they are distressed.
2. Get them to do slow, controlled (not necessarily deep) breathing exercises – use counting in and out to focus attention. *Be very directive until they physically appear to calm.*
3. When they are more settled refocus them to the situation which started the chain - try to understand how they got from this situation to feeling out of control. You might need to stop and reinitiate the breathing exercises intermittently if their distress levels increase as you talk. Then revisit or initiate the care plan and make appropriate follow-up with yourself or arrange to refer them to someone who can work on this with them.

Crises are inevitable for people with BPD and are essential learning opportunities for them to develop a more adaptive repertoire of responses. The aim of your intervention is to assist them to get back to their pre-crisis level of function and to 'live to fight another day'. Wherever possible, avoid taking responsibility for them.

There are a number of options for dealing with problems and the following list can be a useful thing to give to your patient.

- Solve the problem
  - leave, get out of the situation for good
  - change the situation
- Feel better about the problem
  - regulate your emotional response to the problem
- Tolerate the problem
  - accept and tolerate both the problem and your response to the problem
- Stay miserable

7. MANAGE SUICIDALITY SPECIFICALLY

The suicide rate for people with BPD is significantly higher than the general population, however it is difficult to predict who will kill themselves, as the act may be impulsive and without warning. It can be useful to think of people with BPD as chronically suicidal, as it has become a mode for adapting to life.

The onus is on the GP to decide what to do when someone presents as suicidal. You have a duty of care to determine the risk on the basis of their history, what they are saying and what they are doing. Do they have a plan? Have they written a note? Have they given away prized possessions? Are they experiencing symptoms of psychotic depression such as hallucinations or nihilistic delusions?

Try not to automatically over-react when someone expresses suicidal ideation. If you can work out with the patient what has been happening and why they are feeling like they are, you are in a better position to work out what step to take next.

The following anti-suicide interventions can help:

- Fostering and encouraging realistic hope.
- Looking for alternatives to suicide such as focusing on specific problems and generating solutions. This might include referral to an agency which deals specifically with the problem identified.
- Making a connection and tending to the patient's feelings of alienation.
- Looking for internal contradictions and ambivalence regarding the desire to die.
- Decreasing impulsivity by making an internal agreement to wait until the next appointment to discuss the situation.
- Creating distance, if possible, from the patient's access to lethal weapons and drugs.

- Organising a follow-up appointment as soon as feasible with back up contact, e.g. a brief phone call in the interim by yourself or others. Consider contacting MHS Helpline and arranging follow-up along the lines of "I'm seeing them in 3 days and have arranged for them to do various things … can MHS Helpline ring them and see if they've done them?" (MHS Helpline 1800 332 388).
- Teaching them breathing exercises and how to focus attention - anything that changes the physical sensations changes emotions and helps to focus on the real problem.
- Don't promise what you can't deliver and don't blur the boundaries of your professional relationship with them.

Over time you can establish what their chronic pattern of suicidal ideation is, to help you in your decision making in the future and help you identify interventions which work to change the pattern of emotional response for that patient. Remember, how you respond the first time will set the pattern of expectations for the future - if you are calm, inquisitive, validating and operating in a problem solving mode you will provide the foundations for them learning from the crisis and taking responsibility.

8. BE AWARE OF THE LIMITATIONS OF HOSPITALISATION

Admitting an individual with BPD into hospital when they are expressing suicidal ideation can make their long term prognosis worse - it has been shown that admissions statistically increase the probability of successful suicide in the future. Admission reinforces the belief that they are sick and it is someone else's responsibility to make them better. It has been shown to increase regression and passivity and decrease autonomy, and it identifies the hospital, and by default you, as the rescuer. There is also the possibility of a contagion effect with increased risk of more extreme behaviour and evidence that hospitals can actively re-traumatise already vulnerable individuals.

Working with this group of patients is often about taking short term, clinically indicated risks for long term benefits, although knowing that may not necessarily help you with the anxiety you experience in not sending them to hospital. If you don't have a sense that your anti-suicide strategies have made an impact, or that your patient has connected with you into the future, then the first step should be to involve the CATT service for assessment. This avoids the expectation from the patient that they will automatically be admitted. It also usually saves considerable time waiting in DEM and gives you the benefit of an experienced mental health opinion.

9. BE AWARE OF THE LIMITATIONS OF MEDICATION

The temptation to prescribe medication to alleviate an individual's distress is immense. There is often an expectation from the patient that you will prescribe. If they can manage a crisis without external pharmacological assistance, this will greatly enhance their perceived self-efficacy and confidence for future crises. It will assist them in accepting responsibility for things being different and reduce the tendency to view themselves as sick. Co-morbid conditions such as major depressive episode should be treated in their own right but will not prevent the reactivity that is characteristic of BPD.

10. TAKE CARE OF YOURSELF

It would not be unfair to say that individuals with a BPD are over-represented in the group of patients who place health professionals in personal, professional and ethical dilemmas. It is important that you be aware of the risks and protect yourself.

Boundary issues are a particularly challenging issue with people with BPD and are a function of their tendency to regress, misread emotional situations, idealise/devalue relationships and their sensitivity to perceived rejection. Health professionals are responsible for the maintenance of boundaries and are usually legally responsible. Your responsibility is to maintain the independence of the patient, and not be too helpful. The patient should maintain responsibility for their own behaviours and actions, including self harm.

An important problem sign to watch for is if you are treating them as 'special' and not like a usual patient. Recognise your own emotional reaction to the patient. It is almost impossible to maintain an emotionally neutral stance all of the time and the clinical imperative to display neutrality with this group is draining and needs to be dealt with. Commonly this group will lead you to feel frustration, anger, sympathy and a sense of helplessness. You are not immune. It is important to validate your reactions and discuss them with your appropriate network of peers. When not addressed, these reactions can result in you withdrawing from good professional practice and blaming the patient, or attempting to do more and becoming enmeshed. If you think you are working in an enmeshed way discuss the issue with someone else – they might see that you are nudging a boundary you shouldn't. Share the load in these situations and refer to a psychiatrist or psychologist if possible.

Be careful not to be drawn into the human instinct to give physical comfort when someone is helpless, distressed or childlike. It is not unusual for this group to request breaches of boundaries by asking for a hug or some other form of physical soothing. Sometimes you will feel the urge to comfort in this way to allieviate your own sense of helplessness. Remember, touching any patient in any way apart from appropriate physical examination can place you at risk of allegations of professional misconduct. That risk inevitably increases where the patient has the sensitivities and characteristics of BPD.

A useful guide to working with people with BPD is as follows:

- Care, but not too much.
- Get close, but don't get enmeshed.
- Empathise, but protect your own boundaries.
- Hear about human evil, but don't lose optimism.
- Witness intense emotion, but maintain focus.

Finally, remember that with a good program of management, people with BPD are able to improve over time.

Appendix 1: OPTIONS FOR ADVICE AND SUPPORT

Problem Specific Referral

If you have identified the triggering problem then a referral to the agency which deals with that particular problem is appropriate. The sorts of problems which commonly overwhelm this group include: relationship issues, parenting difficulties, financial problems, legal issues, past history factors such as sexual assault. Refer to the card included in this kit for contact details of a number of different types of support services.

Crisis Referral

Where you need urgent assessment, referral should be made to MHS Helpline 1800 332 388. They will triage and refer on - either to DEM for possible admission, to a problem specific agency or to a Community Mental Health Team. MHS Helpline operates 24 hours a day/ 7 days per week.

Referral to Support GP Interventions

Where you have decided to take a more active role in managing/treating this group, it may be appropriate to utilise Community Mental Health Service (CMHS) staff to support the interventions you have made. It is essential that you first discuss the case with MH Helpline staff who will triage the referral, prioritise and respond accordingly. They will identify the appropriate CMHS and establish an appropriate strategy for contact between you, the CMHS and the patient.

Once contact with the appropriate CMHS staff is established, you might ask them to follow-up on suggestions and take the short-term role of 'cheerleader' until you can see or call the patient again. This could be useful in situations where the crisis has already occurred and you are trying to stabilise emotions.

Wherever possible you should provide CMHS staff with the specifics of the strategies you and your patient have developed to use in times of impending crisis. It is also important to establish a clear communication process for the client if they need to call the CMHS if they are in need of some external encouragement to use new skills at times when you are not available.

The more specific you are about what you would like this team to do to support your patient in the community, the more likely it is to happen the way you want. CMHS staff often have considerable skill and experience in working with people with BPD, and they have their own practice protocols. It may be beneficial to take a collaborative approach to ensure workable, efficient and effective strategies for the patient.

Referral for Treatment of Co-Morbid Conditions

Where co-morbid mental health problems such as panic disorder, post traumatic stress disorder, major depression, eating disorder etc are identified, referral to Mental Health Services can be made by contacting MHS Helpline 1800 332 388.

Emotional skills training and some of the other difficulties associated with BPD, such as anger management, depression and anxiety, may be appropriately addressed through referral to a private psychologist or to the psycho-educational group program run by MHS. Information about these programs can also be obtained by contacting the MHS Helpline on 1800 332 388.

Referral can be made to Alcohol and Drug Service via their intake process on 6230 7901 where the primary presenting problem is substance abuse.

Referral for Treatment of the Underlying Personality Difficulties

Referral can be made directly to private sector psychiatrists and psychologists - it is important that you check that the chosen professional has capacity (interest and skill) in working with individuals with BPD and that long term therapy is affordable for the patient (some clinicians bulk bill).

Referral can be made to Mental Health via the Helpline - the capacity of the Community Mental Health Teams to provide appropriate treatment to all who meet criteria for BPD is limited.

ABOUT THIS KIT

This resource kit has been produced by General Practice South to provide General Practitioners with the basic information they need to be able to work more effectively with patients with Borderline Personality Disorder.

It was developed in conjunction with an educational program run by the Division for GPs in April 2003. Sessions were presented by Kereth West, Principal Psychologist, Mental Health Services and Dr Milford McArthur, Psychiatric Liaison, Department of Psychological Medicine, RHH.
The referral information has been revised and updated in November 2008 to reflect the current services available in Southern Tasmania.

Andrée Poppleton from the Division coordinated the project. Lea McInerney, an independent consultant, worked with Andrée on the development of the concept and compiled and edited the kit.

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FURTHER READING

Borderline Personality Disorder: Foundations of Treatment by Krawitz, Roy & Watson, Christine, Seaview Press, 2000