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58 – General Practice Management of the Borderline Personality Disorder Patient

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Dealing with border personality disorder patients is a highly demanding daily task that needs the best approach in family physicians communication skills, use of determinate tools, self-awareness and attitudes.

Borderline personality disorder (BPD) is present in about 6% of primary care patients and it is a chronic disorder in emotional regulation and is characterized by instability in self-image, mood, relationships, and behaviour. It is associated with high rates of suicide and co-morbid mental disorders1. Table 1 summarizes the criteria for the diagnosis of BPD, according to the Diagnostic and Statistical Manual of Mental Disorders, fifth edition.

Psychosocial treatment (see table 2) is the primary therapy but with poor access. Pharmacotherapy should be only an adjunctive component for treating specific symptoms2. Despite advances in the effectiveness of treatment, improvements remain suboptimal in persisting psychopathology and functional impairment remains clinically problematic, even though if they reach the age of 50 or more they usually have a better, less “rocky” life.

Family physician management is essential not only in order to ensure patient-centred quality medical care and co-morbidity management in DBT patients but also to facilitate a long ongoing relationship. Especially when we are talking about DBT patients, which are highly demanding, dependent or even aggressive and manipulative, this is why often we find physicians feeling helpless, angry, frustrated or burned out because of these behaviours. This is one of the reasons why collaborative goal setting will be fundamental. This involves being clear about what it is that the patient is seeking, and agreeing to common goals. A key role for the clinician is to keep one’s eye on these goals, helping the patient to maintain with the chosen strategy, using empathy and, without becoming too rigid3.

The Family Physician – BDP Patients Relationship

When the condition being treated is fundamentally a relational disorder, like DBP, the doctor – patient relationship takes on a particular significance.

The most distinctive characteristics of patients with BPD are their hypersensitivity to rejection and their fearful preoccupation with expected abandonment. They feel that their lives are not worth living unless they feel connected to someone they believe really “cares,” yet their perception of “caring” generally involves unrealistic levels of availability and validation. Within such relationships, an initial idealization can

dramatically shift to devaluation when rejection is perceived. In addition to this external "splitting," patients with BPD typically have internal splitting (i.e., vacillation between considering oneself a good person who has been mistreated, in which case anger predominates, and a bad person whose life has no value, in which case self-destructive or even suicidal behaviour may occur). This splitting is also evident in black-and-white or all-or-nothing dichotomous thinking. In that context, the relationship with professionals is very complicated, as soon as they extol your virtues, as they question the way you work, are hostile if they do not meet their demands, and their uncontrolled impulsivity can explode in the consultation and lose the forms, causing us much discomfort and uncertainty.

So Interpersonal difficulties and challenges, particularly maladaptive help-seeking, are part of the everyday work of caring for people with borderline personality disorder. This need not be a deterrent to becoming involved in their care, but it does require a degree of self-reflection and self-monitoring.

What Kind of Strategies Are Useful?

Because of the problems that the patient has in managing relationships in general, the daily work of the family physician will claim extra capability of self-reflection and self-monitoring.

Family physicians will work with tools that allow them to focus on concrete problems which can be dealt with in short time-lapses (10-15 minutes). In that way they may be more effective and get the patients a more optimistic feeling. These tools are designed to avoid drawing in to the patient pathological personality traits through using non-confrontational and user-friendly techniques and intended either for single visits or longitudinal continuity of care. Motivational interviewing and solution-based problem-solving techniques can be used and a crisis and safety plan should be developed collaboratively. Using validated mobile technologies, like DBT Coach4 program or DBT Medtep, allows behavioural health self-management registration. This does not only facilitate health professional control but empowers patients and families.

A core and specific strategy designed for family physicians is an intervention based on active listening, mindfulness, and strengthening the connection to the patient's most appreciated values. This intervention keeps in mind the professional satisfaction and the concerns of emotional endurance while caring for patients with personality disorders5.

Am I Using the Right Strategies? My Own Thoughts/Feelings Like a Mirror

In caring for patients with BDP, strong thoughts or feelings on the part of the doctor can be used as a reminder to reflect on what is happening in the doctor–patient relationship6: Why won't the patient do what they need to? Who is responsible for change? Am I doing all the work? Am I feeling 'pulled' or 'pushed' to respond in particular ways? Am I responding as I might usually do, or am I treating this patient differently? Asking ourselves this question will allow us to have a better idea of how the relationship is going.

Sometimes BDP patients will invite family physicians to behave differently with them and we can be aware of these invitations without automatically feeling 'cheated' or 'manipulated' and becoming more rigid and inflexible, so that our perspective doesn't get affected.

Which Attitude Should Be Taken?

The first attitude to take should be to improve professional skills in treating these patients if they present themselves to us. We should avoid the next:

- Being too familiar with the patient.
- Using technical "jargon".
- Not being clear about the goals.
- Not setting limits. Although angry outbursts may occur, limits must be set.
- Infrequent follow-up. A venue for frequent follow-up (e.g., telephone or office visits) must be created (e.g.,

virtual visits, telephone or office visits).

- Being too permissive trying to avoid conflict.
- Unidentifying our attitudes towards the patient.
- Adoption of non-professional behaviours like stigmatization or counter transference or complaining “I can’t stand this patient”.

Take Home Message

- The relationship between DBT patients and family-physicians will be a key matter because of the highly instability in mood or relationships that the patients have.
- Family-physicians need to have good communication skills, know how to use several strategies and be able to understand their own feelings or thoughts when dealing with high demanding patients like DBT ones.
- Using the proposed skills and avoiding some attitudes will not only be good for the health of the relationship family-physician – DBT patient but will also improve the professional satisfaction helping avoid burnout syndrome.

Original Abstract

http://www.woncaeurope.org/content/abstract-no-186-workshop-general-practice-management-borderline-personality-disordered

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Table 1. Diagnostic criteria for borderline personality disorder[8]

A pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following

- Frantic efforts to avoid real or imagined abandonment; this does not include suicidal or self-mutilating behaviour covered in criterion 5
- A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation
- Markedly and persistently unstable self-image or sense of self
- Impulsivity in at least two areas that are potentially self-damaging (eg, spending, sex, substance abuse, reckless driving, binge eating); this does not include suicidal or self-mutilating behaviour covered in criterion 5
- Recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour
- Affective instability due to a marked reactivity of mood (eg, intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)
- Chronic feelings of emptiness
- Inappropriate, intense anger or difficulty controlling anger (eg, frequent displays of temper, constant anger, or recurrent physical fights)
- Transient, stress-related paranoid ideation or severe dissociative symptoms

Table 2 Common characteristics of Psychosocial treatments.

Approaches to prototypic borderline personality disorder problems are structured (manual-directed)
Patients are encouraged to adopt self-control (i.e. sense of agency)
Therapists help patients to connect feelings to events and actions
Therapists are active, responsive and validating
Therapists discuss cases, including personal reactions, with other