

How to Treat

PULL-OUT SECTION

www.australiandoctor.com.au

COMPLETE HOW TO TREAT QUIZZES ONLINE
www.australiandoctor.com.au/cpd to earn CPD or PDP points.



Borderline personality disorder

Background

BORDERLINE personality disorder (BPD) is a severe, complex and highly stigmatised psychiatric illness. It is a great mimicker of many other psychiatric illnesses, and is characterised by recurrent suicidal ideation, deliberate self-harm, emotional dysregulation, dissociation and impulsivity. Intense anger, poor self-esteem, chronic feelings of emptiness, fear of abandon-

ment, and transient stress-induced psychosis are also part of the condition. BPD causes profound and long-lasting disruptions to interpersonal relationships and the ability to function in education, work and relationships.¹ Suicide risk is extremely high in this population — at least 75% of people with BPD attempt suicide, and 10% complete suicide.²

International estimates report BPD prevalence of between 1 and 4% and a recent large US community study found a high lifetime prevalence of 5.9%.³⁻⁷ BPD has been found to affect males and females equally, although women and younger adults experience higher levels of disability.⁷ The NHMRC recently estimated 23% of outpatient and 43% of inpatient

mental health service users have a diagnosis of BPD.⁶

The public health impact and cost of BPD is significant. People with BPD have high use of EDs, crisis and primary care services. In addition there are substantial costs associated with resultant detrimental impact on employment, life in the community, and family interactions.

cont'd next page

INSIDE

Symptoms and signs of BPD

BPD: a different conceptualisation

Management

Case study

THE AUTHOR



PROFESSOR JAYASHRI KULKARNI

professor of psychiatry at the Alfred Hospital, Melbourne and director of the Monash Alfred Psychiatry Research Centre.

Copyright © 2017 Australian Doctor
All rights reserved. No part of this publication may be reproduced, distributed, or transmitted in any form or by any means without the prior written permission of the publisher. For permission requests, email: howtotreat@adg.com.au

How to Treat – Borderline personality disorder

Symptoms and signs of BPD

ACCORDING to the DSM-5, eight of the following symptoms are required to make a formal diagnosis of BPD:

1. Significant impairments in personality functioning manifest by:
 - i. Impairments in self-functioning (a or b):
 - a. Identity — Markedly impoverished, poorly developed, or unstable self-image, often associated with excessive self-criticism; chronic feelings of emptiness; dissociative states under stress.
 - b. Self-direction — Instability in goals, aspirations, values, or career plans.
 - ii. Impairments in interpersonal functioning (a or b):
 - a. Empathy — Compromised ability to recognise the feelings and needs of others associated with interpersonal hypersensitivity (namely, prone to feel slighted or insulted); perceptions of others selectively biased toward negative attributes or vulnerabilities.
 - b. Intimacy — Intense, unstable, and conflicted close relationships, marked by mistrust, neediness, and anxious preoccupation with real or imagined abandonment; close relationships often viewed in extremes of idealisation and devaluation and alternating between over involvement and withdrawal.
2. Pathological personality traits in the following domains:
 - i. Negative affectivity, characterised by:
 - a. Emotional lability — Unstable emotional experiences and frequent mood changes; emotions that are easily aroused, intense, and/or out of proportion to events and circumstances
 - b. Anxiousness — Intense feelings of nervousness, tenseness, or panic, often in reaction to interpersonal stresses; worry about the negative effects of past unpleasant experiences and future negative possibilities; feeling fearful, apprehensive, or threatened by uncertainty; fears of falling apart or losing control.
 - c. Separation insecurity — Fears of rejection by (and/or separation from) significant



- d. Depressivity — Frequent feelings of being down, miserable, and/or hopeless; difficulty recovering from such moods; pessimism about the future; pervasive shame; feeling of inferior self-worth; thoughts of suicide and suicidal behaviour.
- ii. Disinhibition, characterised by:
 - a. Impulsivity — Acting on the spur of the moment in response to immediate stimuli; acting on a momentary basis without a plan or consideration of outcomes; difficulty establishing or following plans; a sense of

urgency and self-harming behaviour under emotional distress.

- b. Risk taking — Engagement in dangerous, risky, and potentially self-damaging activities, unnecessarily and without regard to consequences; lack of concern for one's limitations and denial of the reality of personal danger.

- iii. Antagonism, characterised by:

- a. Hostility — Persistent or frequent angry feelings; anger or irritability in response to minor slights and insults.

3. The impairments in personality functioning and the individual's personality trait expression are relatively stable across time and consistent across situations.

4. The impairments in personality functioning and the individual's personality trait expression are not better understood as normative for the individual's developmental stage or socio-cultural environment.

5. The impairments in personality functioning and the individual's personality trait expression are not solely due to the direct physiological effects of a substance (for example, a drug of abuse, medication) or a general medical condition (such as severe head trauma).

BPD — a historical timeline

The condition has been described in various ways over many years. Beginning with a description in 1938 by psychoanalyst Adolph Stern coining the term 'the borderline group', this condition has not been well-defined or named. The term "borderline personality" was used to indicate that the condition fell between psychotic and neurotic disorders.

Today, it is apparent the condition is viewed as a feature of personality developmental failure, hence its inclusion in the DSM-5 section under "personality disorders." However, this approach adds to the stigma and does not help clinicians to assist their patients. The term itself is ambiguous, with the word "borderline" evoking questions about the condition's legitimacy and the term "personality disorder" stigmatising the individual as 'inadequate'. Added to the inherent confusion and blame contained in the term is considerable stigma by many in the healthcare services.

Borderline personality disorder: a different conceptualisation

BPD is a challenging disorder with high morbidity and mortality. Poor pharmacological treatment and resource intensiveness for the management strongly suggest we need a refocused approach.

The role of trauma in early life with resultant poor attachment to the main carer/parent is thought to be a highly significant factor in the development of later life BPD.

Recent prospective, longitudinal studies on the development of BPD outline many potential antecedents

of the disorder and highlight the importance of very early experience — particularly the parent-child relationship — in predicting later BPD symptomatology.¹⁰

Reviews of the existing literature on the relationship between trauma and BPD also suggest biological and temperamental vulnerabilities, combined with the experience of trauma, may contribute to the development of personality pathology.¹¹⁻¹³

A biopsychosocial approach

to the aetiology of BPD suggests genetic vulnerability, combined with early life trauma leading to disrupted attachment to the main carer/parent plus ongoing social stresses, is a common picture for many patients with BPD.

The next iteration of the WHO disease classification system — the ICD-11 (International Classification of Diseases — Version 11), is challenging the concept of BPD as a "personality disorder" and including a section on "chronic

post-traumatic stress disorder". This may well provide a clearer rationale for patients and clinicians alike to refocus the cause and treatment of this complex condition.¹⁴

Borderline personality disorder: reconsidered as complex post-traumatic stress disorder?

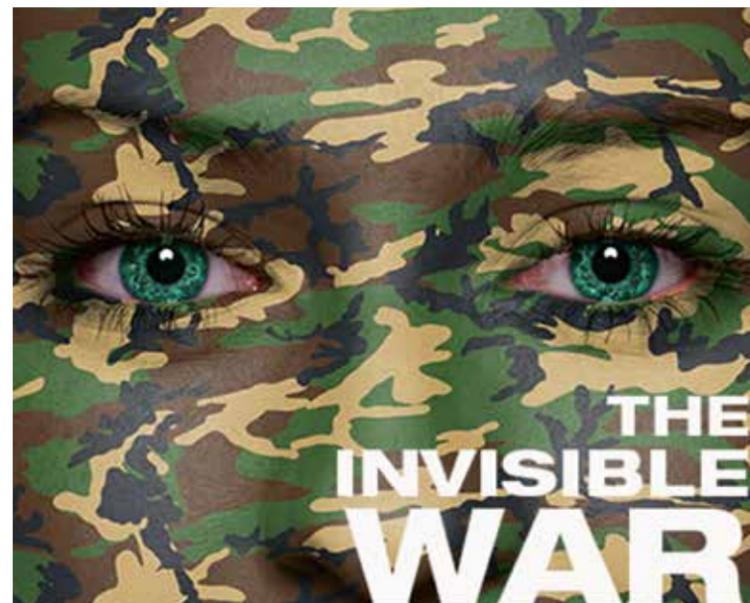
In many patients diagnosed with BPD, there is a significant history of sexual, physical or emotional abuse or emotional neglect and

invalidation. Even if the history of early life trauma is not immediately apparent or readily discussed, over a period of time and engagement with a clinician, the story is present in about 85% of patients.¹

The symptoms of chronic or complex PTSD when compared with the main symptoms of BPD (table 1), as reported in the DSM-5, have a similarity that enables an easier framework with which both clinicians and patients may engage.⁸

Table 1. BPD compared with chronic PTSD

Borderline PD	Chronic PTSD
<ul style="list-style-type: none"> • Frantic efforts to avoid real or imagined abandonment. • A pattern of unstable and intense interpersonal relationships characterised by alternating between extremes of idealisation and devaluation. • Identity disturbance, such as a significant and persistent 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). • Recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour. • Emotional instability due to significant 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, recurrent physical fights). • Transient, stress-related paranoid thoughts or severe dissociative symptoms. 	<ul style="list-style-type: none"> • Problems regulating feelings, which can result in suicidal thoughts. • Explosive anger, or passive-aggressive behaviours. • A tendency to forget the trauma or feel detached from one's life (dissociation) or body (depersonalisation). • Persistent feelings of helplessness, shame, guilt, or being completely different from others. • Feeling the perpetrator of trauma is all-powerful and preoccupation with either revenge against or allegiance with the perpetrator. • Severe change in those things that give the sufferer meaning, like a loss of spiritual faith or an ongoing sense of helplessness, hopelessness, or despair.



Management

Acute treatment: specific assessment for acute deliberate self-harm

IF a new patient presents with deliberate self-harm, the need to build rapport is a significant early task. Specific questions asked in a sensitive manner, around the presenting problem, will be critical to rapport building and risk assessment:

Specific questioning about the act of deliberate self-harm:

- “What was happening that led to you cutting yourself?” Allow enough time to answer this question. You may have to wait patiently for the patient to trust you enough to discuss this question.
- “How did you plan this?” With this question, you are trying to gauge impulsivity or prior planning.
- “Where were you?” Try not to be too inquisitorial, but attempt to gauge the level of planning around her act of self-harm.
- “Who was around?” as above.
- “What did you feel when cutting? Afterwards?” With this question, you are trying to understand the motivation for self-harm, in particular if this is used as a “tension release” action.
- “What did you do after cutting yourself? Ask about whether they attended to the wound or whether they told someone about it. Do they feel ashamed about it? Are all these aspects the same as with previous acts of self-harm?”

Many patients with BPD may report feeling enraged, having heightened anxiety or extreme sadness before cutting and report feeling better seeing blood flow or experiencing physical pain on cutting. This short-lived decrease in tension is often replaced by feelings of shame and despair. A recurrent pattern of self-harming behaviour followed by shame and despair, with increasing anxiety leading to more self-harm can result.

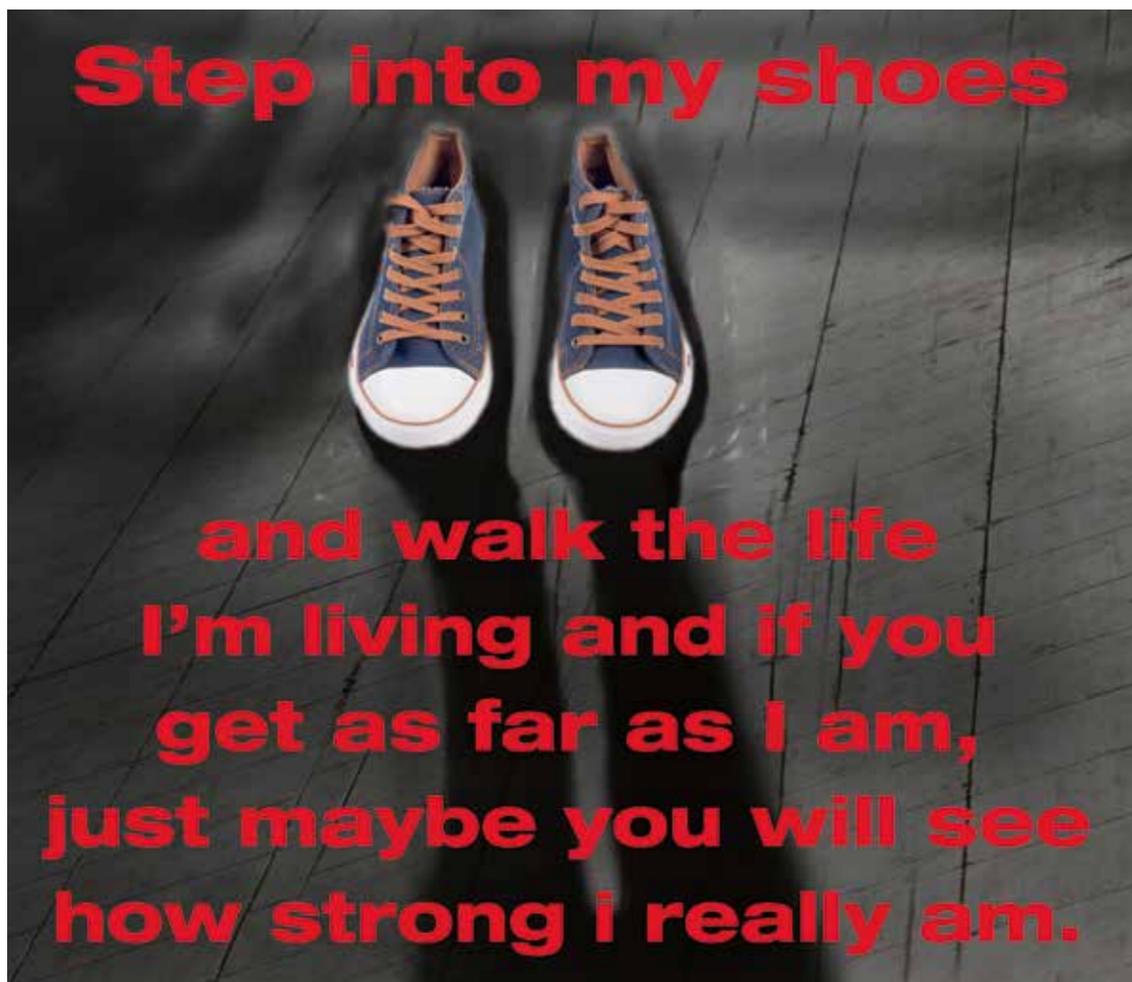
It is very important to ask about the particular thoughts the patient had prior to the self-harming episode, and whether there had been any recent contact with anyone who had previously been involved in a conflictual situation with them.

Patients may misperceive chance comments as major criticisms. If they reveal a history of abuse or neglect in early life, then a trigger for current self-harm may be a recent encounter with the perpetrator of early life trauma or a reminder of the perpetrator or a traumatic incident. In this session it is important to allow the patient to recall any recent thoughts or interactions they may have had that led to the act of self-harm.

As the treating doctor, you need to ascertain the level of suicidality. It is important to ask about suicidal ideation when a patient presents with any act of deliberate self-harm.

Sample questions at this stage may include:

- “Do you feel you want to be dead?” If the answer is yes,



I'm sorry I'm ugly.
I'm sorry I'm fat.
I'm sorry I lie.
I'm sorry I cut.
I'm sorry I'm broken.
I'm sorry I'm damaged.
I'm sorry I want to die.
I'm sorry for existing.
I'm sorry.

A recurrent pattern of self-harming behaviour followed by shame and despair, with increasing anxiety leading to more self-harm can result.

then ask why.

- “What are the things that stop you/that push you to self-harm?”

Unhelpful behaviours by doctors

These include: not asking about details in the mistaken belief that a discussion will lead the patient to do it again or use a more successful method; a belief held by the doctor that self-harm is “morally wrong” will prejudice against good, empathic treatment for the patient; and thinking that cutting behaviour is not a ‘real’ attempt may trivialise the patient’s very real distress.

It is critical that the treating doctor does not blame the patient or convey exasperation or invalida-

tion of the patient’s circumstances. If you openly discuss suicidal ideation and attempts, you permit the patient to put the self-destructive feelings into words — which is a key therapeutic tool. Plus, you validate their distress and empathise, which is critical in rapport building. You will need to begin discussing alternate methods of tension release rather than self-harming, and an empathic approach for the level of distress that leads to the self-harm is a better, useful focus.

If, for example, you assess your patient as having harmed themselves as an attempt to kill themselves, then they are at high risk of suicide. In this instance, you will have to arrange an urgent consultation with psychiatric services such as a crisis team or ED assessment. If they have a treating psychiatrist or receive care from a psychiatry team, then it is important to contact them, even out of business hours, to let them know about the patient’s situation. Trust your clinical instinct in making a risk assessment — particularly noting any new stressors, different self-harm methods and any changes in the planning or aftermath of self-harm.

Sustained treatment approaches

Once the acute issue around risk management is dealt with, it is important to take a full background history. This will include:

Past history of hospitalisations

Obtain a detailed history of presentations to EDs, past admissions to public and private psychiatry wards. Encourage your patient to detail what happened in contacts with hospitals and listen to details about perceptions of the treatment. Allow the patient to ventilate any anger or dependence on hospital staff. This conversation has the dual goals of allowing the

patient to express their feelings thus aiding rapport-building as well as enabling you to understand whether hospitalisation is useful or an added stress. This is important in future management strategies.

Past history of treatments

- Have they worked or not?
- What psychological treatments have been tried? Allow the patient to give their frank opinion of these. Remember that current trends for advocating mindfulness techniques do not suit all patients, and may not work in times of severe agitation. Ask about past treatment with dialectical behavioural therapy specifically, since this type of therapy has been shown to have good efficacy with BPD symptoms, although the ‘fit’ between patient and therapist needs to be right. Ask about any and all therapies — with mental health professionals and others.
- What medications have been tried? Medication management in BPD is a complex, messy area and many patients are prescribed several drugs — from as many as four psychotropic classes.⁶ It is not unusual for patients to receive antidepressants plus mood stabilisers plus antipsychotics plus benzodiazepines. Often, the patient will tell you about many side effects and resultant intense antagonism to taking certain medications. Listen for details about adverse reactions to even small doses of medication.

It is common for BPD patients to have heightened sensitivity to medications, with putative underlying biological predisposition to such reactions related to the interaction between immune system responses and early life trauma. Check for particular medication treatments for anxiety and depression symptoms. Ask about self-medication with alcohol or street drugs as well as over the counter medicines plus herbal and other complementary preparations.

- Check for alcohol and drug use as self-medication attempts and as secondary comorbidity.¹⁹

Past physical health history

There is a high level of undiagnosed polycystic ovary syndrome in women with early life trauma.^{17,18} It is important to look for signs and symptoms of this endocrine disorder — which can have its own impacts on self-esteem (obesity, hirsutism) as well as altered medication metabolism issues and a propensity for developing diabetes and infertility.

Ask about menstrual cycle-related relapses in mood and anger symptoms. Many women have noted a cyclical deterioration in mental state and asking about this is important in terms of treatment strategies and to validate the patient’s observations. Similarly, some women have significant relapses of BPD symptoms in the perimenopausal phase and asking about this may further elucidate

cont'd next page

from previous page

the reason for deterioration — often in early perimenopause — which can occur well before the physical symptoms of menopause appear.

Past history of past or current legal issues

As a result of uncontrolled anger and impulsivity, there may be issues such as driving offences, unpaid fines or assaults, as well as homelessness as a result of broken relationships.

Detailed family history

It is critical to take a detailed family history and not just of familial illnesses. Include details about the patient's current supports and current and early life family dynamics. Details of early life, experiences at school, work and relationships are important. In particular, look for early traumas of separation from the main carer, deaths or divorce/separations in the family, sexual, physical abuse or emotional invalidation and neglect, harsh critical parenting, family stresses or alcoholism in parents.

Be prepared for big 'gaps' in memory of early events. Larger than expected gaps in memory tend to point towards traumatic episodes with either conscious or unconscious repression of events. A history of family violence and trauma history is a critical part of your consultation, but needs to be conducted very sensitively. Eliciting details of trauma can be difficult, and sometimes, different sessions with varying approaches may be needed. A special toolkit to assist primary care physicians has been developed to identify past and current violence and trauma.²²

Making and explaining the diagnosis of borderline personality disorder

The diagnostic term "borderline personality disorder" is at best, meaningless to many patients and at worst, highly stigmatising. Your patient may have heard the diagnosis before or been given it — but it is important to discuss this diagnosis in context of the patient's life. Explore and explain the broad range of the symptoms as the 'mimicker' of many others. Highlight that it is a spectrum disorder, with many different degrees of severity.

Draw the connection for your patient between the impact of early life trauma on resultant poor self-esteem, anxiety, mood shifts, cognitive challenges, dissociation and physical health issues. The connection with early life trauma is very comforting for many patients — it changes the dynamic for them from being considered as "manipulative, badly behaved" individuals to "survivors of trauma, with PTSD type symptoms".

Using the diagnosis of "complex trauma disorder" as a better descriptor of the aetiology is often very comforting for the patient.

Ongoing management

Environmental factors

Monitor environmental stressors by asking if there is a current relationship that is violent in nature and use community resources to assist with this. Maintaining



Using the diagnosis of 'complex trauma disorder' as a better descriptor of the aetiology is often very comforting for the patient.

school, higher education or work is critical for future or current independent living.

Relationships

Most patients with this condition experience difficult relationships in many areas of their lives. If possible, refer patients to a psychologist to help them understand how and why they sabotage useful relationships or develop harmful ones. If referral is not possible, you will need to provide this type of therapy for your patient. While this work does require expertise in psychodynamic knowledge, it is very useful for the GP to set aside regular longer appointments to engage in psychotherapy.

Psychotherapy by the GP for BPD

There are many types of therapy, but whichever type you engage in with your patient it is vital that you recognise that your role as a therapist is to contain the anxiety and rage. This means that even with deliberate provocation, you must be calm and professional at all times. Be consistent by keeping to

the regular, longer appointments and provide sufficient forward warning about your holiday or other leave. Set up weekly psychotherapy appointments at a time that will not be impacted by other emergency patients and do not be distracted during the sessions.

Consistency is an important form of limit-setting — which is important for BPD patients, who may try to get more frequent appointments to see you or bargain with you that they want more from you because "you are the only one who understands". While this suggests there is a good rapport, the boundaries must be adhered to and setting firm limits on the therapy appointments is crucial.

Therapies

Dialectical behaviour therapy is a cognitive-behavioural approach that emphasises the psychosocial aspects of treatment.¹⁶ The theory behind the approach is that people with BPD react in a more intense way and prolonged manner towards certain emotional situa-

tions, especially in relationships. Due to the lack of emotional validation in early life and the other aetiological factors, patients with BPD experience extreme swings in their emotions, see the world in black and white, and seem to always be jumping from one crisis to another. They often do not have adequate methods for coping with these sudden, intense surges of emotion. This therapy teaches skills that will help in this task.

Dialectical behaviour therapy helps the patient identify their strengths and build on them so they can feel better about themselves and their life. It has a cognitive base and helps the patient identify thoughts, beliefs and assumptions that make life harder.

The therapy asks patients to complete homework assignments, role-play new ways of interacting with others, and to practise skills such as self-soothing when upset. These skills, crucial to the therapy, are taught in weekly sessions and reviewed in weekly homework. The individual therapist helps the person to learn, apply and master the particular skills.

Individual weekly psychotherapy sessions emphasise problem-solving behaviour for the past week's difficulties that arose in the patient's life. Self-injury and suicidal behaviours are the first priority, followed by behaviours that may interfere with the therapy process. Quality of life and working toward improving this may also be discussed. Individual sessions focus on minimising stress responses and helping enhance self-respect and self-image.¹⁵

The 'Push-Pull'/'Love-Hate' dynamic

In any clinical encounter with BPD, be aware of patients' potential to 'test' the strength of relationships, including your patient-doctor relationship. Often patients with BPD describe intense invalidation experienced in early life as impairing their capacity to truly believe that anyone could really value or love them. Hence in their romantic relationships, there will often be a testing out of their partner, sometimes by deliberate provocation to see whether or not their partner will stay with them. It is a complex set of actions, since a common fear experienced by patients with BPD is the fear of abandonment. Thus, the provocation or attempted sabotage of relationships is driven by a mixture of poor self-esteem plus a desperate longing for caring and nurturing.

This complex dynamic can be played out by the patient in testing the doctor by being late for or not attending psychotherapy sessions, or by trying to provoke angry responses in the doctor through words or deliberate self-harm. In these instances, it is critical for the doctor to remain constant, to reinforce that sessions will continue and to maintain a calm, professional, empathic manner. Angry reactions on the part of the doctor or stopping therapy sessions will be perceived by the patient as abandonment and can set back their progress or even result in

cont'd page 24

from page 22

further self-harm. The ‘push-pull’ dynamic describes the patient’s attempt to ‘push’ the therapist (or partner) away with hurtful words or actions, but then feel abandoned if the therapist (or partner) begins to react indifferently or negatively and try to frantically ‘pull’ them back in. The ‘pull’ can involve further threatened self-harm, desperate over-emotional apologies with self-denigration, exaggerated promises to change and many other overblown responses.

As doctor and therapist, it can be useful to explain this dynamic to your patient and discuss instances of such responses.

Psychological techniques to manage trauma/rage

Mindfulness is a modern reworking of ancient meditation traditions, principally Buddhist. The aim of mindfulness therapy is to help people be aware of thoughts and bodily sensations and in so doing, be able to enable better coping with day-to-day emotions and problems. There are mindfulness therapists and apps where the goal is to establish a daily mindfulness practice, often mindfulness of the breath. There is no attempt to change the thinking, but simply to become more aware of the unhelpfulness of some thoughts.

Reflecting on a difficult situation as it is happening, or soon after, or staying with an upsetting emotion for some length of time to become more familiar with it are both techniques that mindfulness therapists use. The aim is to allow the patient to have a different, easier relationship with problematic thoughts, emotions and bodily sensations.

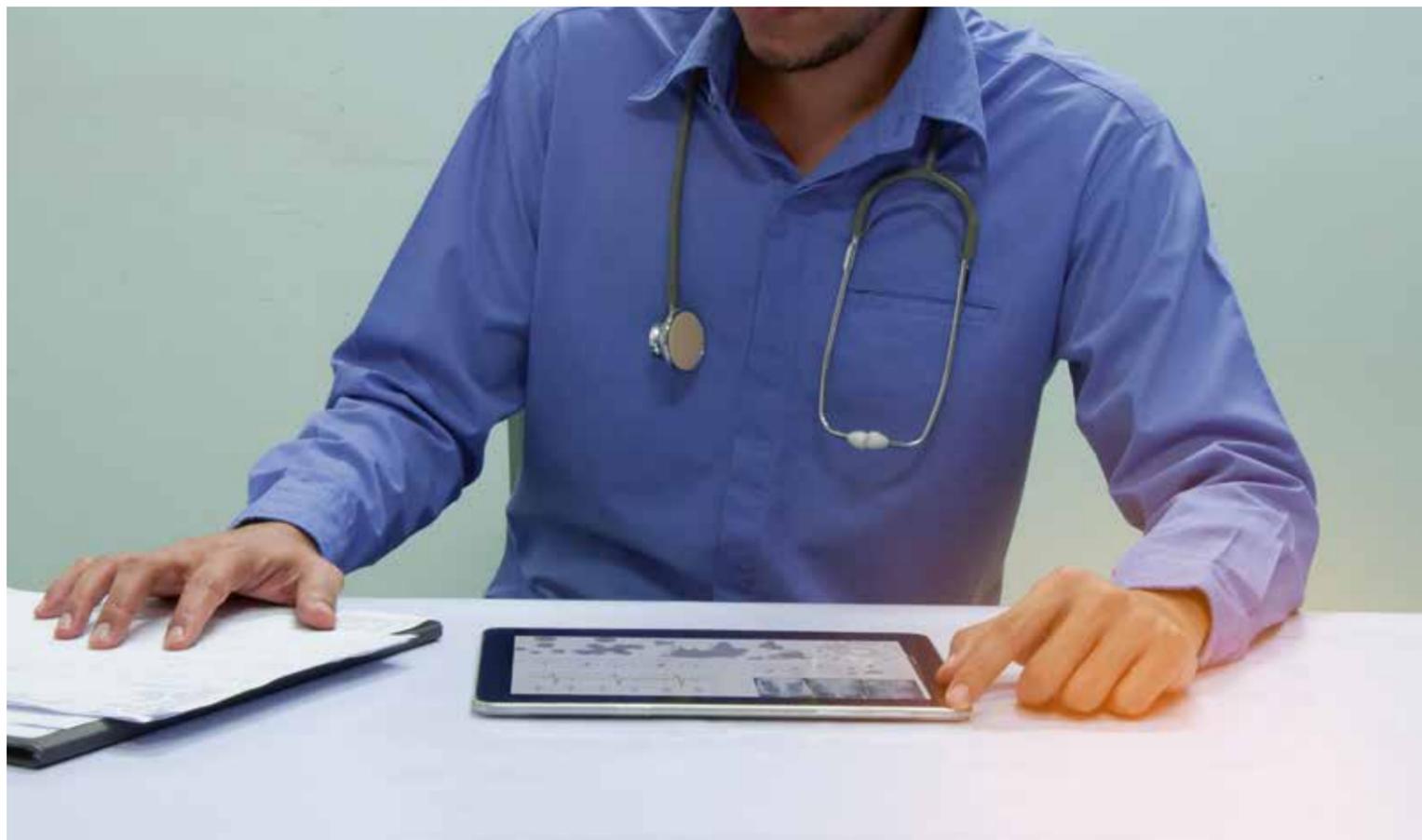
Like any other form of therapy, real change requires hard work and commitment, and it is best to offer mindfulness therapy to BPD patients during their non-crisis periods. Mindfulness training can be very helpful to eventually minimise the level of rage and related responses, but needs to be practised.

Medication management

The overall strategy with medication management is to minimise and rationalise all psychotropic medications. Patients with BPD receive several psychotropics from different classes, with little overall gain. Be careful of adding medications to a growing list of psychotropics and be prepared to decrease and remove medications for your BPD patient.⁶

Antidepressant medications

Since patients with BPD experience significant periods of mood fluctuations, many are prescribed antidepressants, with a tendency



for ongoing prescribing of these, despite any clear evidence of sustained mood impact.²¹ It may be important for you to cease an antidepressant that is causing side effects such as weight gain or sedation but do not suddenly stop an SSRI/SNRI or the patient may experience profound withdrawal symptoms. Plan slow reductions in medications with your patient, as a collaborative exercise. Slow downward titrations with regular reviews. A clear plan will further engage your patient and enable you to minimise any drug side effects. Short activity antidepressants may be better, since it is expected that mood will fluctuate. In this situation, agomelatine or vortioxetine may be used for shorter time frames without significant withdrawal issues. As per the guidelines for each medication, monitoring of physical health is important.

Mood stabiliser medications

If your patient gives a history of mood fluctuations, consider low-dose lamotrigine or topiramate. Both these medications have some NMDA-receptor activity and may be useful in containing mood swings as well as helping cognitive processes.⁶ Allergic responses to lamotrigine are not uncommon and anxiety is occasionally worsened with topiramate, so close monitoring of physical health and mental health is required.⁶

Anxiolytic medications

Many patients with BPD have very high levels of anxiety, regardless of their current situation. Excessive use of benzodiazepines,

alcohol or cannabis all lead to secondary morbidity with addiction issues and cognitive impairment. Very low dose quetiapine (12.5-50mg per day of immediate release formulation) may be a safer anxiolytic medication.²⁰ This off-label use can be discussed with your patient as an emergency medication for severe anxiety or panic. Monitoring its use and assessing sedation is important. Being careful with driving and operating machinery when taking quetiapine is critical advice. Also, quetiapine in frequent doses can lead to weight gain.²⁰

Long-term follow-up

Be consistent and reliable. If you have decided to provide psychotherapeutic input, do so in a consistent manner, with the main goals being to validate your patient’s emotional world as well as containing anxiety and self-harming impulses.

Plan future sessions with yourself as the physical health carer if you have decided not to provide therapy for your BPD patient. In this case, arrange for a psychotherapist and/or psychiatrist. You will need to be consistent and reliable in your availability to deal with issues of medications or episodes of self-harm and liaise with other mental health professionals.

Develop an emergency plan with your BPD patient. Discuss who supportive contacts are and discuss who should be contacted in case of self-harm or feeling “out of control” in the future. Contacts can include specific family members, friends, or even Lifeline and other emergency services.

Special issues for the primary health practitioner in caring for BPD patients

Time

Time management in your practice may be difficult anyway, and BPD patients do need longer sessions in order to get a deeper understanding of their situation and implement treatments. However, it is possible to set up regular longer appointments for such patients and engage with them over a longer period of time.

Dependency

BPD patients have often been deprived of consistent care and positive attention, thus a kind doctor who provides professional care and empathy may become highly sought after. As long as firm limits are set and professional boundaries kept strictly in place, dependency on the doctor is not in itself a bad thing for the patient. As a therapist, the doctor needs to be aware of the BPD patient’s neediness as well as strengths — and to encourage the latter. Forewarning of planned absences by the doctor is important in order to prevent relapses in the dependent patient with BPD.

The need for support and taking care of yourself

Working with BPD patients can be difficult and frustrating, particularly if the patient acts on their impulses to self-harm frequently or tries to provoke the doctor to anger. The need to be calm, optimistic, and continue with the planned treatment can be difficult and wearing. However, even small improvements in the patient’s mental state can enable them to make huge changes for the

better in their life. Minimising medication changes, rationalising doses and thereby improving side effects of drugs can be highly significant for a patient with BPD.

Frustration with health and mental health systems is common, but the role that GPs play as their patients’ advocate in dealing with systems is critical. Ongoing contacts with key personnel in the hospital systems may permit the BPD patient’s GP to better negotiate admissions if needed.

It is important for GPs to limit the number of BPD patients under their direct care, if possible. In this instance, GPs need to know their own limits and capacity to work with BPD patients.

The emotional intensity and ensuing crises can be very difficult to handle if the GP has a large caseload of BPD patients. This results in either disinterest in the patient, which is antithetical to good treatment, or to GP burnout.

Sharing the work of treating people with BPD is important. If possible (and always with the patient’s permission), collaborating on developing treatment and emergency plans with designated family and others in the patient’s life is a useful approach. Explaining to significant others in the patient’s life about the nature of the condition, what to expect and what is helpful and not helpful is key to treatment. Since the condition is poorly understood, the role of the GP in demystifying the illness, and taking away some of the stigma is crucial. Changing the family and friends’ view that the patient is ‘just behaving badly’ to seeing them as having an illness, can make considerable differences to outcomes.

Case study

EMMA’S father left the family when she was six years old, after which time her mother remarried. Emma’s stepfather sexually abused her from ages 8-12 but she has only just disclosed this to you at her previous consultation. Emma

has a younger sister and she feels very protective of her. She believes she had to “shield” her sister from her stepfather. Emma felt further betrayed by her mother, who did not believe her when she tried to speak about the abuse. Emma left

home at 16 and lived with her aunt, who provided positive support for Emma. She completed secondary school and despite several setbacks, finished primary school teacher training. Emma loves her work and gets good reports from

her principal, but has used up all her sick leave due to bouts of depression and deliberate self-harm.

Emma has had several admissions to hospital psychiatry wards,

Online resources

Primary care physician toolkit
www.maprc.org.au/family-violence

References

Available on request from
howtotreat@adg.com.au

from page 24

with little improvement. She is taking sertraline (200mg/day), olanzapine (15mg/day) and oxazepam (30mg/day). She weighs 95kg, is 162cm tall and has facial hirsutism.

Emma is now 25 and she presents to your practice after lacerating her thigh with a small kitchen knife. The laceration is fairly superficial, but this is the fourth time this month that Emma has done this. How do you proceed?



General principles:

- Remember that Emma is the victim of significant early life trauma.
- You are an authority figure and a key ‘validator’.

Working on the deliberate self-harm:

- Use a sensitive questioning approach to discuss the self-harm.
- Build on the rapport you have established since Emma disclosed the sexual abuse history. Ask how she has felt since the disclosure.
- Check for suicidal ideation/plans.
- Discuss in an open manner the context of this deliberate self-harm attempt. Did she feel very anxious beforehand? How did she feel afterwards? Were there any triggers for this episode?
- In discussion with Emma, set up psychological therapy — either with a psychologist or with you.

Physical examination and actions

- Examine the laceration (professional contact to build a therapeutic bridge), suture (if needed), and dress wound, all in a sympathetic manner.
- Do not dismiss her lacerations as an ‘insignificant’ attempt.
- Test for polycystic ovary syndrome.
- Test for diabetes.
- Consider down titration and eventual cessation of olanzapine, which is a weight-gaining medication.
- Consider adding in lamotrigine. Once Emma is stable you can start to decrease the oxazepam.

Conclusion

BORDERLINE personality disorder is an unhelpful term for a poorly understood mental illness that carries significant mortality and morbidity.

Using a diagnostic term such as

chronic post-traumatic stress disorder or complex trauma disorder can change perceptions and open up new treatment modalities.

The GP or primary care physician is in a special and unique position

of being able to contain the BPD patient’s difficult symptoms, prevent further damage through rationalising medication as well as developing long-term therapeutic strategies that can make huge dif-

ferences in the patient’s and their family’s lives.

There is hope that in the near future, new classification of this disorder (ICD-11) will promote better acceptance of people with

this condition.

Furthermore, research into the neurobiological impacts of early life trauma may provide better treatments for people who have been highly stigmatised to date.



How to Treat Quiz

Borderline personality disorder —
20 January 2017

INSTRUCTIONS

Complete this quiz online and fill in the GP evaluation form to earn 2 CPD or PDP points. We no longer accept quizzes by post or fax.

The mark required to obtain points is 80%. Please note that some questions have more than one correct answer.

GO ONLINE TO COMPLETE THE QUIZ

www.australiandoctor.com.au/education/how-to-treat

1. Which TWO statements regarding borderline personality disorder are correct?

- It is a great mimicker of many other psychiatric illnesses.
- An increased risk of suicide has not been described in this patient population.
- BPD causes profound and long-lasting disruptions to interpersonal relationships and the ability to function in education, at work and in relationships.
- BPD is more common in females than in males.

2. Which THREE statements regarding the symptoms and signs of BPD are correct?

- A range of symptoms are required according to the DSM- 5 to make a formal diagnosis of BPD.
- The impairments in personality functioning and the individual’s personality trait expression are relatively stable across time and consistent across situations.
- The impairments in personality functioning and the individual’s personality trait expression may be normative for the individual’s developmental stage or socio-cultural environment.
- The impairments in personality functioning and the individual’s personality trait expression are not solely due to the direct physiological effects of a substance or a general medical condition.

3. Which TWO factors are thought to contribute to the development of BPD?

- Trauma in early life with resultant poor attachment to the main carer.
- Early abuse and neglect.
- Obesity in childhood.
- Early exposure to passive cigarette smoke.

4. Which THREE are features of chronic PTSD?

- Explosive anger, or passive-aggressive behaviours.
- Persistent feelings of helplessness, shame, guilt, or being completely different from others.
- A tendency to forget the trauma or feel detached from one’s life or body.
- Transient, stress-related paranoid thoughts or severe dissociative symptoms.

5. Which TWO questions are appropriate when assessing for acute deliberate self-harm?

- Why do you keep doing this to yourself?
- What was happening that led to you cutting yourself?
- What did you do after cutting yourself?
- Why did you not go to the ED for treatment?

6. Which four combinations of drugs are commonly prescribed in patients with BPD?

- Antidepressants plus mood stabilisers plus antipsychotics plus amphetamines.

- Antidepressants plus mood stabilisers plus antipsychotics plus antihistamines.
- Antidepressants plus mood stabilisers plus antipsychotics plus benzodiazepines.
- Antihypertensives plus mood stabilisers plus antipsychotics plus benzodiazepines.

7. Which TWO statements regarding history are correct?

- Past or current legal issues are very rare in BPD.
- There is a high level of undiagnosed polycystic ovary syndrome in women with early life trauma.
- Many women may note a cyclical deterioration in mental state.
- Larger than expected gaps in memory may simply be indicative of a forgetful nature.

8. Which THREE statements regarding ongoing management are correct?

- Environmental factors, such as a violent relationship or school issues, need attention.
- Psychotherapy may help patients understand how and why they sabotage useful relationships or develop harmful ones.
- Vary the duration and timing of the psychotherapy sessions, as this helps the patient transfer the skills of learning inconsistency into their daily lives.
- Dialectical behaviour therapy is a cognitive-behavioural approach that emphasises the psychosocial aspects of treatment.

9. Which TWO statements regarding management are correct?

- Dialectical behaviour therapy teaches the skills to cope with sudden, intense surges of emotion.
- The role of the therapist is to take the patient out of crises, hence the need for regular and frequent follow-up, as well as appointments on demand.
- Dialectical behaviour therapy helps the patient identify their strengths and build on them so they can feel better about themselves and their life.
- Dialectical behaviour therapy asks patients to complete homework assignments, role-play new ways of interacting with others, and to practise skills such as self-soothing when upset.

10. Which THREE statements regarding medication in BPD are correct?

- The overall strategy with medication management is to use sufficient medication, in the appropriate combination, so the patient feels well and in control of their life.
- Many patients are prescribed antidepressants, with a tendency for continual re-prescription of these, despite any clear evidence of sustained mood impact.
- Low-dose mood stabilisers may be useful if there is a history of mood fluctuations.
- Excessive use of benzodiazepines, alcohol or cannabis all lead to secondary morbidity with addiction issues and cognitive impairment.

NEW RULES

Currently, when you complete a How to Treat quiz, the CPD points you earn are uploaded every six weeks to the RACGP website. However, due to the implementation of a new notification fee, Australian Doctor will now only upload your points to the RACGP, on request, at the end of this triennium (31 December 2019).

You will still be able to download a certificate of completion at any time after successful completing the online quiz. You will also be prompted to self-report the CPD points you have earned to either college at any time at no cost.

A record of all your points earned through How to Treat quizzes will be available under ‘achievements’ in the How to Treat section of our website. For ACRRM members, PDP points will be uploaded to ACRRM quarterly.

Australian Doctor apologises for any inconvenience but as How to Treat is free, independent and receives no sponsorship, we need to make this change to avoid incurring tens of thousands of dollars in RACGP fees.

Australian Doctor Education

NEXT WEEK’S HOW TO TREAT

Personalised care with new type 2 diabetes agents. The authors are **Dr Angela Lee**, Sydney, NSW, and **Professor Stephen Twigg**, Sydney, NSW.

HOW TO TREAT Editor: **Dr Claire Berman**
Email: claire.berman@adg.com.au