

## The management of borderline personality disorder in primary care

### *What is borderline personality disorder?*

Borderline Personality Disorder (BPD) is a complex, persistent, pervasive pattern of emotional, cognitive, interpersonal and self-regulation problems which affects every aspect of a person's life. Often becoming apparent in adolescence, these patterns may lead to break down of relationships, drug and alcohol misuse, homelessness, self harm and suicide attempts. Eating disorders, anxiety and depression and post-traumatic stress symptoms commonly co-occur with BPD.

The symptoms as set out in the psychiatric manuals (ICD-10 and DSM-IV) are: fear of abandonment (e.g. staying in an abusive relationship because of fear of being alone); unstable relationships involving idealising and devaluing the other person; unstable sense of self (reflected in sexual orientation, career goals, friends desired, values); impulsivity (spending, sex, substance use, shoplifting, reckless driving, binge eating); recurrent suicidal behaviour, gestures or threats or self mutilating behaviour; marked reactivity of mood; chronic emptiness or boredom; intense anger or difficulty controlling anger; transient stress-related paranoia or dissociative symptoms. It is one of the 'Axis II' disorders. There are three clusters of personality disorders, BPD is one of the 'impulsive' cluster.

BPD is often associated with a history of abuse or neglect within the family of origin, biological factors may also play a part. People with BPD may behave in ways that appear to invite rejection. They may feel that no help is ever good enough. They can sometimes sabotage all attempts at help. This can be very frustrating for practitioners. Skills and knowledge are required to enable us to 'rise above' rejecting, judgmental or compulsive responses and to reflect calmly about what may be happening.

### *How common is BPD?*

Estimated prevalence of people with personality disorder in the general population is 10-13% (BPD is just one of these disorders). Among mental health service users, prevalence of BPD is around one in ten, among psychiatric inpatient populations one in five..

People with BPD frequently become 'revolving door' patients. Admission to hospital often produces deterioration and should usually be seen as a last resort intervention to prevent suicide. Medication can alleviate symptoms but will not remove the essential emptiness of being and 'living hell' which is BPD.

### *What can we do in primary care?*

- *Referring on:*

'In Britain we have the remarkable phenomenon that large numbers of quite severely disordered individuals who require considerable therapeutic effort

are deemed 'untreatable'. (1). There may be particular problems in primary care when specialist services reject people with personality disorder and refer them back to GPs. Like other clinical staff, GPs and other disciplines within primary care teams have little specific training in the diagnosis, treatment and management of personality disorders; yet they are frequently the first point of contact for many service users.

The endless cycle of rejection can intensify the distress and therefore the difficult behaviour of some people. It also means that those who are receiving intensive support, especially in in-patient settings, can experience numerous barriers in returning to the community and in coping effectively.

The National Institute of Mental Health (NIMHE) guidance (2) cites evidence that the negative attitudes and practices of many agencies reflect a lack of knowledge and skills in relation to the needs of people with personality disorder. The NIMHE capability framework (3) sets out a programme of training and attitude change along with service developments designed to address these problems throughout primary care, secondary care, housing, social services, education and other systems.

Long-term attachment and stable support systems are the essence of what is needed by people with BPD, who may expect rejection every step of the way. Referral to specialist evidence-based therapies such as cognitive behavioural therapy (CBT) for BPD, known as 'schema focused therapy' or dialectical behaviour therapy (DBT) is only part of the picture. Services are patchy across the country and you may find yourself pleased by a knowledgeable response, or frustrated by inconsistent and judgmental responses you may still receive from community mental health teams or psychological therapies services (e.g. this person is not mentally ill, this person is untreatable).

However, this situation is rapidly changing as services develop nationally. You can work through your own organisation and commissioners to improve the experience of this group as they make their way through services with your help.

- *Management in the surgery*

In primary care practice as elsewhere one clue to thinking about a diagnosis of BPD for a patient is how dealing with them makes you feel. If you feel uneasy, that the person seems unpredictable in their responses (e.g., very easy to talk to and capable one day, very difficult and uncooperative the next), if you feel you are constantly 'fire-fighting' an overwhelming array of life crises and problems; if you feel helpless in your attempts to help, consider this diagnosis as a possibility.

The management of these problems should begin with listening to the patient in a non-judgmental way, validating their experience of life and of services. Do not feel tempted to defend yourself or others, also avoid colluding with complaints you feel are unwarranted. In order to do this you will need a place to discuss the feelings and behavioural urges brought out in you by the

interaction so that you can get help staying non-judgmental. No one can do this alone, do not be fooled into thinking you are the exception!

DBT operates by making a hierarchy of behaviours to reduce (eg self harm) and behaviours to increase (eg, asking for help before self harming, saying no without being aggressive). Interactions with the patient then revolve around working on this hierarchy. This helps to avoid the needless 'fire fighting' mentioned earlier and gives a structure for both parties to hang on to. An adaptation of this could be used for management within primary mental health care, or within mainstream GP health care.

- *What if my patient is suicidal?*

People who are expressing suicidal intent or making suicidal gestures should be dealt with using individual protocols agreed between patient and GP at a time when the patient is not suicidal. Clinical judgement will be needed to assess the seriousness of the threat. Most people with BPD need an allocated care co-ordinator. Good communication between all involved is essential: Linehan (4) describes the oscillations those around people with BPD experience, between rescuing and persecuting the person. If two people at opposite extremes of this oscillation meet, an argument often ensues about how to respond, in the midst of which the patient is entirely forgotten.

- *A checklist*

Here is a checklist for your surgery: do you have

- Staff with a basic understanding of what BPD is?
- Staff who can be non judgemental and validating towards their patients?
- Staff with space to reflect on their practice and keep each other on the non-judgmental straight and narrow?
- A wider system to interact with with similar skills and knowledge?
- Access to specialist service which do not exclude people with BPD and who can provide evidence-based treatments
- Vast amounts of patience as people reject your help repeatedly, because they are afraid to fail?

- (1) Gunn, J. (2000). Future directions for treatment in forensic psychiatry. *The British Journal of Psychiatry*, **176**, 332-339.
- (2) National Institute for Mental Health in England. (2003a). Personality disorder: No longer a diagnosis of exclusion.
- (3) National Institute for Mental Health in England. (2003b). Breaking the cycle of rejection: The personality disorder capabilities framework.

- (4) Linehan, M. M. (1993). *Cognitive-behavioural treatment of borderline personality disorder*. New York: Guilford Press.