Borderline Personality Disorder in Primary Care

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Borderline Personality Disorder (BPD)

Learning Objectives:
1. To understand prevalence and related statistics of BPD that are important to primary care.
2. To understand the diagnostic criteria and conceptualization of BPD.
3. To discuss the use of structure, boundary-setting, and constructive responses to behavior in the context of primary care treatment.

BPD: A Little Self Reflection...
What Do You Know?

- What's an individual with BPD like?
- How do you feel when you hear that a patient has BPD?
- How might you feel after seeing a patient with BPD?
BPD: Prevalence and Related Statistics

- Most people have never heard of BPD even though it accounts for 1/4 of all psychiatric hospital admissions.
- Affects primarily women.
- The prevalence rate for the diagnosis of Borderline has been found to be 4 times higher in primary care (6.4%) than in the general population (1.6%).

BPD is not BIPOLAR:
How to know?

DIAGNOSING

- Thorough Psychosocial Assessment; including family history and medical history
- Three Major Differentiators:
  1. Cycle of Mood dysregualtion
  2. Duration of Mood dysregulation
  3. Precipitating Factor of Mood dysregulation

BPD: Prevalence and Related Statistics

Risky:
- Suicidal ideation very high in primary care populations (21.4%)
- Up to 10% complete suicide.

Underidentified in Primary Care:
- About half of patients who have BPD were “recognized by their PCPs as having an ongoing emotional or mental health problem or had received mental health treatment during the past year”.

Gross et al. (2002)
BPD Diagnosis: Controversial

CONS:
May be overdiagnosed by clinicians who are frustrated by a “difficult patient”.
Stigma does exist.
The name Borderline Personality Disorder seems to suggest the condition is a personality flaw.

PROS:
Appropriate referral for treatment can be extremely helpful.
Recognizing BPD may enhance understanding patients with challenging behaviors.
Physicians may develop rapport, feel less frustrated, and even have a therapeutic effect by learning about BPD.

BPD: Diagnostic Criteria
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.

Five (or more) criteria must be met for a diagnosis of BPD.

BPD: Diagnostic Criteria
Criteria reflect the individual’s significant difficulty regulating...

1.) Emotions
Shifts in mood usually lasting only a few hours and rarely more than a few days.
1. **Emotions (cont.)**

* Anger that is inappropriate, intense or very difficult to control.

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2. **Impulsivity**

* Self-destructive acts, such as self-mutilation or suicidal threats and gestures that happen more than once.

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**Self-destructive Acts/Self Harm**

Those with BPD frequently feel overwhelmed or anxious and seek ways to reduce their frustration, stress, or pain.

Don't have an outlet, so self-injurious behaviors may be experienced as releasing pent-up emotions.
BPD: Diagnostic Criteria

2.) Impulsivity (contd.)
* Two potentially self-damaging impulsive behavior patterns. These could include:
  - alcohol and other drug abuse,
  - compulsive spending,
  - eating disorders,
  - gambling,
  - shoplifting,
  - compulsive sexual behavior,
  - reckless driving

BPD: Diagnostic Criteria

3.) Experience of self
not knowing who one is or changing what one wants to do on a daily basis
* Marked, persistent identity disturbance shown by uncertainty in: self-image, sexual orientation, career choice or other long-term goals, friendships, values.

BPD: Diagnostic Criteria

* Chronic feelings of emptiness or boredom.
  "I remember describing the feeling of having a deep hole in my stomach. An emptiness that I didn't know how to fill."
BPD: Diagnostic Criteria (contd.)

4.) Cognitive experiences

*transient, stress-related paranoid ideation or severe dissociative symptoms

(Experiencing things as unreal)

BPD: Diagnostic Criteria (contd.)

5.) Interpersonal relationships

* frantic efforts to avoid real or imagined abandonment.

Note: Do not include suicidal or self-mutilating behavior.

BPD: Diagnostic Criteria

* a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation (chaotic-love/hate)
BPD: Diagnostic Criteria

Additional examples of dysregulation experiences in the area of relationships... (Goodwin, 1999)

- Alternating clinging and distancing behaviors (I Hate You, Don't Leave Me).
- Great difficulty trusting people and themselves.
- Sensitivity to criticism or rejection.
- Feeling of "needing" someone else to survive.
- Heavy need for affection and reassurance.
- People with BPD tend to have an unusually high degree of interpersonal sensitivity, insight, and empathy.

BPD: Conceptually Speaking...

Characteristics stem from the intensity of emotional instability:

Intensity of emotions leads to a tendency to perceive...

- others' behavior as malevolent (related to inappropriate, angry outbursts)
- abandonment (even minor loss may be experienced as panic)
- extreme emotional responses to intimacy (manifested in splitting and idealization/devaluing)
- dissociation (helps the patient separate from the intensity of his/her emotions)

BPD: Conceptually Speaking...

Intensity of emotions leads to: Primitive Defense Mechanisms

- desperate, impulsive, often unhealthy attempts to make themselves feel better or essentially, manage their emotions.
- What's seen as manipulative or impulsive behaviors are desperate attempts to obtain a response from their environment.
- The outcome of these behaviors may be soothing and empowering initially, but behaviors are often self-damaging in the long run.
BPD: Conceptually Speaking...

Difficult to have good relationships if you can’t regulate emotions

but...

without good relationships it’s also difficult to regulate emotions because much more emotionally vulnerable.

_Cyclic problem_

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BPD: Conceptually Speaking...

- Individuals with BPD are born with an innate biological tendency to react more intensely to lower levels of stress than others and to take longer to recover. (Linehan, M.)
- They were raised in environments in which their beliefs about themselves and their environment were continually devalued and invalidated
- These factors combine to create adults who are uncertain of the truth of their own feelings and who are confronted by three basic dialectics they have failed to master (and thus rush frantically from pole to pole of):
  - vulnerability vs invalidation
  - active passivity (tendency to be passive when confronted with a problem and actively seek a rescuer) vs apparent competence (appearing to be capable when in reality internally things are falling apart)
  - unremitting crises vs inhibited grief.

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EFFECTS OF BPD ON HEALTHCARE UTILIZATION for Primary Care:

- Greater number of office visits
- Greater number of prescriptions
- Greater number of phone calls
- More frequent specialist referrals
BPD & SOMATIC PREOCCUPATION

- BPD affects immunity to medical illness?
- BPD manifests first or only as somatic preoccupation
- BPD co-exists with genuine medical conditions

Classic BPD symptoms with Primary Care Nuances

- Medically Self Sabotaging Behavior - Intentional self harming behaviors
- Perceptions of Illness - BPD perceive themselves as more disabled
- Pain Syndromes - Disturbances in regulation of pain sensations & states
- Prescription Misuse/Abuse - 64% have co-morbid substance abuse problems. Self dysregulation
- HIV - Self regulation issues of substances abuse & promiscuity
- Skin Picking/Excoriation - Self harm/mutilation of any kind
- Factitious Illness - the need to have a medical exs. to elicit emotional involvement of others

Other Medical Phenomena Associated with BPD

- Plastic Surgery - BPD PS pts. requested higher number of areas for surgery, perceived PS as more serious, and had least satisfaction post op (body image issues)
- Rheumatoid Arthritis - Rather than direct relationship, more likely mediated by early developmental trauma & subsequent effects on immunity
- Obesity - Associated difficulties with self regulation. Binge eating disorder
- Disability - As BPD is often r/t childhood victimization, this theme often perpetuates itself in adulthood as medical disability
1.) Structure, structure, structure

Actively structure the interview

Respond to repeated office calls by voicing commitment to the relationship within the context of negotiated boundary setting.

Schedule brief, frequent visits and give verbal outline of the territory to be addressed in future visits, when a long list of issues or new last-second issues are brought up.

LaFerpa, E. (2007)

2.) Remain calm and empathetic to diffuse hostility.

**EMPATHY ATTENTION RESPECT**

- Respond to emotional outbursts by: recognizing feelings while requesting appropriate behavior.
  
  "I can see how you might be angry about this, and I’d like to talk with you about it if you can lower your voice".

- If the patient does not respond: voice awareness of the heightened emotion at present and the need for a break until this is reduced, when the conversation will resume.

3.) Beware of Splitting

Beware that agreeing with an a devalued view of another provider, may be a form of splitting, unhelpful to the patient’s treatment.

or that...

Being overly protective of another treaters goodness, may invalidate the perceptions of the individual with BPD.
BPD: Office Management

4.) Look out for counter-transference

- Positive counter-transference: Clinician unconsciously responds to idealization in a manner so as to continue extracting accolades from the patient. (Ex: “giving in” to excessive special requests, responding to requests for medications that are not medically warranted.)

- Negative counter-transference: Clinician unconsciously responds to devaluation by ignoring, avoiding, or devaluing complaints.

5) Open honest discussion of the role of emotions/life stressors in medical concerns.

Chronic rotating physical complaints: attempt to focus on a specific complaint with brief discussion of patient’s psychosocial concerns.

LaForge, E. (2007)

6.) Partner-up for physical examinations.

LaForge, E. (2007)
BPD: Office Management

7.) Educate about BPD if appropriate

Reviewing the diagnostic criteria for BPD with the patient may lead the patient to feel more understood by the provider. This may help the patient accept treatment efforts in general. LaForge, E. (2007)

BPD: Office Management

8.) Know that suicide and self-harm will be issues.

Patients with BPD are likely to acknowledge suicidal thoughts very commonly.

Take these behaviors seriously, assess and document consistently, consider options if needed, but also know that suicidal ideation and self harm are ways in which patients with BPD cope with their disorder.

If you are too uncomfortable with this, refer to someone else. LaForge, E. (2007)

Meds for Borderline?

- Drugs that enhance brain serotonin function may improve emotional symptoms in BPD.

- Mood-stabilizing drugs that are known to enhance the activity of GABA, the brain’s major inhibitory neurotransmitter.

Psychopharmacological treatment of BPD is complex and not expected to solve the problem.
Therapy for BPD
Therapy is the primary mode for treating BPD, so always consider this option as a primary step.

Dialectical Behavior Therapy
Is a cognitive-behavioral treatment program developed by Marsha Linehan, Ph.D. in the early 1980s

5 CORE STRATEGIES:
1. Dialectics
2. Problem solving (behavior therapy)
3. Acceptance (validation)
4. Case management strategies
5. Communication strategies

The Four Stages of DBT Individual Therapy

Stage I: Moving From Being Out of Control of One's Behavior to Being in Control
Goal: 1. Keep client alive & 2. Improve functioning
Targets: 1. Address life-threatening behaviors and those that interfere with effective treatment and may destroy quality of life 2. Increase behavioral skills

Stage II: Moving From Being Emotionally Shut Down to Experiencing Emotions Fully
Goal: 1. Help client deal with problems of everyday living
Targets: 1. Increase emotional Experiencing 2. Decrease emotional suffering

Stage III: Building an Ordinary Life, Solving Ordinary Life Problems
Goal: 1. Help client experience emotions
Target: 1. Increase emotional Experiencing 2. Decrease emotional suffering

Stage IV: Moving From Incompleteness to Completeness/Connection
Goal: 1. Help client move toward a life that involves an ongoing capacity for experiences of joy and freedom
Targets: 1. Focus on helping client reach a sense of connectedness to a greater whole

DBT Skills Training

CORE MINDFULNESS * EMOTION REGULATION * DISTRESS TOLERANCE * INTERPERSONAL EFFECTIVENESS

Taught in skills groups

Developed over time
Like building muscles
Will eventually become integrated into everyday life
CORE MINDFULNESS SKILLS

1. What Skills?
   - Observing
   - Describing
   - Participating

2. How Skills?
   - Non Judgementally
   - One Mindfully
   - Effectively

INTERPERSONAL EFFECTIVENESS SKILLS

Using Objectiveness Effectiveness: (DEARMAN)
   - D Describe
   - E Express
   - A Assert
   - R Reinforce
   - M Mindful
   - A Appear Confident
   - N Negotiate

Using Relationship Effectiveness: (GIVE)
   - G Gentle
   - I Interested
   - V Validate
   - E Easy Manner

Self Respect Effectiveness (FAST)
   - F Fair
   - A Apologies (no Apologies)
   - S Stick to value
   - T Truthful

DISTRESS TOLERANCE SKILLS

surviving without making it worse

- Distract – Wise Mind ACCEPTS
  Activities, Contributing, Comparisons, opposite Emotions, Pushing away, Thoughts, Sensations

- Self Soothe – Use the Five Senses

- IMPROVE the moment
  Imagery, Meaning, Prayer, Relaxation, One thing in the moment, Vacation, Encouragement

- Pros and Cons
  Making it worse by? tolerating distress by?
Emotion Regulation

* Teaches clients how to manage negative and overwhelming emotions while increasing their positive experiences.

** Three goals:**

1. Understand one’s emotions
   - Recognizing & naming emotions/Primary vs. secondary emotions/emotion Myths

2. Reduce emotional vulnerability (PLEASE MASTER)
   - PL – represents taking care of our physical health and treating pain and/or illness. E – is for eating a balanced diet and avoiding excess sugar, fat, and caffeine. A – stands for avoiding alcohol and drugs, which only exacerbate emotional instability. S – represents getting regular and adequate sleep. E – is for getting regular exercise. MASTER – refers to doing daily activities that build confidence and competency.

3. Decrease emotional suffering
   - Letting Go & Opposite Action

The primary care clinician is likely to have the essential role in initiating psychotherapy treatment. (Present as an adjunct, not a replacement, for primary care) – abandonment sensitivity

If the patient hasn’t considered therapy, or has previously resisted, the PCP is well-positioned to create a functional and stable working relationship, that can facilitate the referral and embracing of therapy, possibly initiating a lifetime of change. (LaForge, 2007)

DBT RESOURCES

- Individual & Group Therapy
- On-Line – Apps / Blogs / Forums
- SELF HELP Skills training manuals