

LEARNING OBJECTIVES

- Understand the definition and patient presentation of borderline personality disorder
- Discuss the use of structure and boundary-setting during treatment
- Describe several behaviors that providers can expect when treating borderline patients and ways to respond in a therapeutic way

The patient with borderline personality disorder

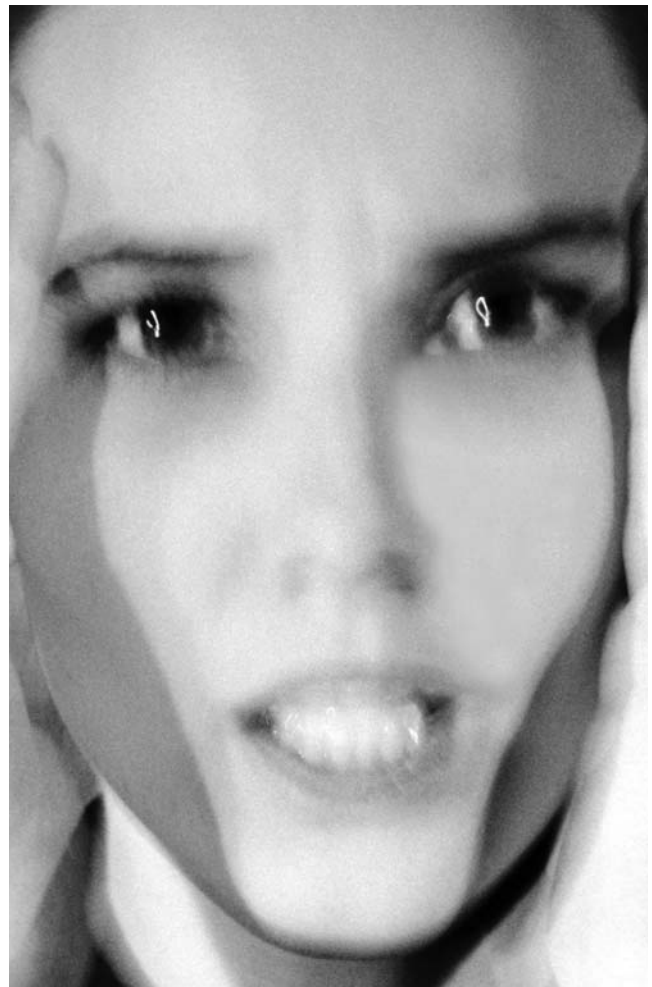
Caring for borderline patients is demanding, complex, and time consuming. A few simple strategies can improve outcomes and even strengthen your relationship with the patient.

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“**B**ecause of a lack of previous successful continuity relationships, the patient with borderline personality disorder is usually poorly prepared to understand the nature of the social contact on which good primary medical care is predicated.”¹

After even a cursory look at the diagnostic criteria for borderline personality disorder (BPD), many PAs are convinced they have already encountered a patient, relative, or friend with the pattern of impulsivity and instability in interpersonal relationships, self-image, and affect that is the hallmark of this condition (see Table 1, page 48). Perhaps they had not realized that the person in question had a personality disorder with well-defined symptomatology. Maybe they simply thought of the person as “unstable” or of the relationship as “challenging.” BPD as a diagnosable condition is fairly new. Only in 1980 did the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, the authoritative guide to psychiatric conditions, adopt a final set of diagnostic criteria for BPD, after decades of studies attempted to define and refine the psychiatric community’s consensus.² Given how recently this occurred, nonpsychiatric clinicians may still be uncertain of the identifying characteristics of BPD. Identification is the key to working successfully with patients with BPD, however, and once the clinician is aware of the diagnosis, strategies are available to improve the relationship with the patient.

Patients with BPD present to primary care for a variety of nonpsychiatric concerns and experience the full spectrum of physical ailments seen in the general population. However, these patients present challenges beyond those of diagnosing and treating their physical conditions. They “often consume a disproportionate amount of the [clinician’s] time, they can



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be extremely demanding, and they tend to experience complicated or incomplete recovery from illness, either organic or functional”³ (see Table 2, page 49).

This article provides a discussion of strategies that may be employed to enhance the therapeutic alliance with patients with BPD in a primary care setting. It is intended to complement a January 2000 *JAAPA* article that discussed the diagnosis of BPD in primary care settings. The assumption here is that the diagnosis has already been made and that the clinician now needs help in working with the patient.

STRATEGY 1: Structure, structure, structure

Consider providing the patient with a written treatment contract that outlines expectations and policies and that may clarify the responsibilities of both parties. Addressable issues might include the length of office visits, the number of visits allowed per given time period, patient options in the event of an emergency or after-hours crisis, and the consequences of noncompliance with the contract. Patient compliance may actually be secondary to the awareness that the medical provider is comfortable setting limits. This can send an important message to patients with BPD regarding stability and continuity, which has likely been lacking in their previous interpersonal experiences.¹

Studies suggest that patients with BPD are not offended by such boundary setting.⁴ In contrast, most are keenly aware of the excessive demands they may place on a provider and may be surprisingly respectful of the clinician’s needs. “Self-interest on the part of the [provider] can actually be reassuring to a borderline patient whose previous caretakers have fallen under the weight of the patient’s dependency needs.”¹

With regard to office visits, the clinician should not hesitate to actively structure the interview. The diffuse thought processes of the BPD patient may be confusing and interfere with the clinician’s ability to efficiently conduct an interview. Consequently, “the greater the organization around the interview, the greater the level of security experienced by the BPD patient. This security should, in turn, diminish some of the clinician’s anxiety regarding the patient’s unpredictable volatility.”⁵

Other examples of borderline behavior requiring boundary setting might include repeated crisis or emergency appear-

ances in the office without an appointment; repeated phone calls to the office or the provider’s home; and requests for inappropriate house calls or other special favors. These may be ways that a borderline patient “tests” the availability and patience of a clinician. The clinician should verbally describe this pattern to the patient and help the patient realize that such behaviors may relate to an underlying fear of abandonment or may be attempts to increase the intensity of the relationship by forcing the provider to demonstrate a commitment to the relationship.⁵

Finally, it is not uncommon for borderline patients to bring a long list of issues that they feel need addressing. The clinician may find it helpful in this instance, as when patients

“Patients who have borderline personality disorder appear to present with a high degree of somatization.”

bring up new issues and complaints at the tail end of a visit, to request that the patient return for another visit to extend the discussion. Scheduling patients for brief, frequent appointments and giving them a verbal outline of the territory to be covered in future visits can be extremely effective. The provider might ask the patient to pick, or prioritize, the top three issues. Reassurance can then be provided that additional concerns can be addressed over a series of subsequent visits.

STRATEGY 2: Remain calm to diffuse hostility

Patients with BPD may become angry or act out, often in response to seemingly small triggers. It is critical that the clinician acknowledge the anger and then request that borderline patients limit its expression. Providers should remain calm and avoid matching the patient’s escalating mood with their own; “paradoxically, expression of anger by the [clinician] reinforces and intensifies these patients’ engagement in the relationship.”³ The clinician should attempt to be as neutral and calm as possible, reminding the patient that the

KEY POINTS

- Once the clinician is aware of the diagnosis of BPD, strategies are available to improve the relationship with the patient.
- Strategies include setting appropriate boundaries, remaining calm when the patient is angry, being aware of splitting, watching for counter-transference, providing conservative medical management, partnering up for physical examinations, educating patients about the condition, and understanding that self-mutilating behavior and threats of suicide are a normal part of BPD.
- According to H.R. Searight, “by serving as a consistent, yet firm, [caregiver] who will ‘call’ the patient on his or her self-destructive behavior, the primary care [clinician] will be providing valuable psychosocial therapy.”

COMPETENCIES

●●● Medical knowledge

●●●●● Interpersonal & communication skills

●●●●● Patient care

● Professionalism

● Practice-based learning and improvement

● Systems-based practice

anger response is a “style of behavior” that is chosen and that it can be changed.⁶ “The response to the patient’s emotional outbursts should include a recognition of the patient’s feelings with a clear request for appropriate behavior (‘I can see you are angry. I can talk with you if you will lower your voice’). If the patient does not respond, the [practitioner] should terminate the conversation with the message that it will be resumed later when the patient obtains some control.”⁵ When a patient appears angry with the provider, the provider might ask the patient what it is that he or she is doing to bother the patient. The answer to the question will often give insight into the patient’s thinking and “enhance the patient’s sense of control.”⁵

STRATEGY 3: Beware of splitting

Splitting—the inability to integrate good and bad images of other people, or the oscillation between narcissistic entitlement and extreme self-criticism⁵—is common in those with BPD. A patient may regale the clinician as the best practitioner *ever* while elucidating the perceived shortcomings of a previous provider. Or the patient may insist that a coworker was excessively rude or inappropriate in their treatment of the patient, as borderline patients are likely to “present them-

selves to a member of the health care team as abused and neglected by other members, apparently in the hope of getting extra attention from the provider to whom they are talking.”¹ Perhaps the patient expresses self-contempt in the face of what appear to be minor mistakes or setbacks, for BPD patients may split the perception of themselves.

Splitting may help borderline patients test the waters, so to speak, within treatment teams by becoming aware of various team members’ frustrations and support. Splitting is often unconscious—the result, experts believe, of the preservation of primitive defense mechanisms.⁷ Practitioners must realize that reacting to a borderline patient’s splits may reinforce some behaviors. “When clinicians are aware that validating borderline patients’ projections of badness (ie, agreeing with their devalued view of another treater) can lead to splits, this awareness can lead members of teams to bond together by invalidating the borderline’s attributions (ie, being protective about the other treater’s goodness). Such responses negate the partial reality of the borderline patient’s perceptions. Moreover, the idea that, to prevent splits, staff members need to protect each other against negativity confers too much power on the patients’ hostility. This too is harmful.”⁷

Practically speaking, if the patient routinely takes issue with some member of the health care team, providing continuity may help. Consider limiting the number of staff interacting with the patient; have the patient see one receptionist, one medical assistant, one nurse, and one practitioner, if possible.⁶ Take the time to alert members of the team as to salient features of BPD and what to expect from such patients, including the tendency to split. If all else fails, consider consulting with a psychiatric specialist for help. Understand and expect that splitting may be an integral part of BPD—learn to acknowledge it without succumbing to patients’ idealization or devaluation of you or themselves.

STRATEGY 4: Look out for counter-transference

Counter-transference may be linked to splitting and is occurring when a patient’s idealization or devaluation of a clinician is influencing that clinician’s emotional response to the patient. In the case of idealization, the clinician (likely unconsciously) behaves in a manner so as to continue extracting accolades and attention from the patient. This may be observable as a provider “giving in” to special requests of the patient or as viewing the patient as particularly vulnerable or in need of nurturance. Concessions include extended visit times, response to requests for medications that are not necessarily medically warranted,⁶ or, in general, deviation from expectations for the relationship as defined in the initial contract.

Negative counter-transference may also occur. Devaluation of the practitioner by the patient may lead the practitioner to develop an extreme dislike of the patient. This may lead to situations where the provider ignores or devalues the patient’s complaints or attempts frequent referrals to avoid interactions with the patient.⁴

How does the clinician know if counter-transference is becoming a problem? Indicators include “feelings of fear or

TABLE 1. Diagnostic criteria* for borderline personality disorder

1. Frantic efforts to avoid real or imagined abandonment
2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation
3. Identity disturbance; markedly and persistently unstable self-image or sense of self
4. Impulsivity in at least two areas that are potentially self-damaging (eg, spending, sex, substance abuse, reckless driving, binge eating)
5. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior
6. 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)
7. Chronic feelings of emptiness
8. Inappropriate, intense anger or difficulty controlling anger (eg, frequent displays of temper, constant anger, recurrent physical fights)
9. Transient, stress-related paranoid ideation or severe dissociative symptoms

*Five of the nine criteria must be met for diagnosis.

Adapted with permission from *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision; DSM-IV-TR*. Washington, DC: American Psychiatric Association; 2000.

“Borderline patients may not be rational or objective in their interpretation of an examination involving them as a patient.”

anxiety in response to the patient’s emotional volatility, feeling tempted to punish the patient, feeling despair with a patient’s self-destructive behaviors, succumbing to idealization/devaluation or splitting, and feeling too close to the patient.”⁶

Most importantly, “be aware of your tendencies to need to be acknowledged and flattered, a caretaker, a rescuer, in control, correct, and sexually desirable.”⁶ The clinician may need to consult with colleagues or a personal therapist to maintain appropriate control over such feelings.

STRATEGY 5: Strive for conservative medical management

The term *conservative* refers to a careful striking of balance with regard to medical management of a patient—“neither over-responding [n]or under-responding to the patient’s medical problems.”⁷³ Every patient with BPD should receive a thorough, routine medical evaluation. However, the clinician should also be cautious about ordering numerous laboratory tests or other diagnostics, particularly in the case of vague somatic complaints, because “overuse of diagnostic resources promotes a ‘sick’ role for the patient.”⁷³ Patients with BPD do appear to display a high degree of somatization.^{2,8}

If a thorough history and physical examination reveal no abnormalities or reasonable explanations for the symptoms, a careful and respectful discussion of the role of emotion and mental health in physical wellness may be warranted. While many patients with BPD react poorly to being told, “it’s all in your head,” they often respond well to a thoughtful discussion of the relationship between life stressors and health issues.¹ “For the patient with chronic rotating physical complaints, it is valuable to focus on a specific complaint at each visit in conjunction with a brief discussion of the patient’s psychosocial circumstances. Over time, these patients may be able to appreciate the relationship between psychosocial stressors and somatic complaints.”⁷⁵ Take care to be explicit and thorough in your discussions, as patients often have difficulty with abstraction and ambiguity.¹ And while it may be essential to draw patients into discussions regarding their mental health during the course of treating their physical ailments, Sansone suggests handing over involved and lengthy discussions to a therapist.³ This provides a way to “reinforce the division of labor” between primary-care clinicians and mental health providers.³ Relay to patients that they are most benefited by consulting with an expert in mental health issues, just as they are most benefited by relying on you as an expert with a well-defined skill set that is nevertheless limited to nonpsychiatric medicine. Such a suggestion may actually inspire confidence in

patients, as they feel someone possessing expertise is acknowledging them as having a condition worthy of attention.

STRATEGY 6: Partner-up for physical examinations

Particularly during “sensitive” examinations, such as female pelvic or breast examinations, having a nurse or other staff member in the examination room is a good idea. “Patients with BPD have significant boundary problems and may misinterpret these procedures as indicative of a personal relationship rather than reflecting a medical examination.”⁷⁹ Setting aside the legal implications that could arise from a patient’s complaint, borderline patients may not be rational or objective in their interpretation of an examination involving them as a patient. In fact, those with BPD constitute the majority of patients who falsely accuse therapists of sexual involvement.¹⁰ An objective bystander may provide a necessary buffer.

STRATEGY 7: Educate

Consider reviewing the diagnostic criteria for BPD with patients so that they may see how their current symptoms connect to the official criteria. This helps both the provider and the patient realize that manifestations of BPD that seem especially troubling to both parties are “normal” parts of the condition. Patients may be surprised to recognize patterns in their behavior, and they may also recognize these patterns in the future, perhaps even working to “break” them or abandon them with the realization that they are pathologic. Much like an overeater may keep a diary documenting the feelings and events that led to overindulgence, a borderline patient may be able to recognize triggers after appropriate education.

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TABLE 2. Issues and behaviors associated with borderline personality disorder

Clinical depression does not respond to pharmacotherapy
Manipulative suicide attempts have occurred
Self-abusive behavior (eg, self-inflicted cuts or burns) occurs
The patient does not adhere to treatment for chronic or acute medical problems with little apparent concern about consequences
The patient displays a sense of entitlement and excessively demands clinician time and attention
The patient expresses disproportionate, intense anger toward clinician
Broken bones or lacerations are incurred during angry outbursts (eg, banging arm against a wall, smashing a window)
The patient “splits” the clinician (eg, primary clinician characterized as “all good” and consultant as “all bad”)
Clinician becomes anxious about or fearful of patient’s emotional volatility

Adapted with permission from Searight HR. Borderline personality disorder: diagnosis and management in primary care. *J Fam Pract.* 1992;34(5):605-613.

Additionally, open communication helps the patient to appreciate the provider's awareness of the relevant features of the illness. The patient may feel understood, and feeling understood by a health provider may go a long way toward helping the patient embrace treatment efforts, if they are undertaken. "A primary care [clinician] who is knowledgeable about the syndrome and who can communicate empathy and an understanding of the symptoms will greatly reduce the patient's fearfulness and dramatically increase rapport."⁵

"Tolerating recurrent suicidal thoughts is part of working with patients with borderline personality disorder."

Consider, also, reframing BPD as *emotional intensity disorder*. Although this renaming has not been universally accepted, there is considerable support within the psychiatric community for such a name change. Many believe that *borderline personality disorder* is a misnomer, an antiquated term used to describe BPD as residing on the "border" between psychosis and neurosis, and that a name change would allow both patients and laypeople to gain a better understanding of the salient features of the disorder. Patients may also feel that *emotional intensity disorder* is a more descriptive and less derogatory term than *borderline personality disorder*.

STRATEGY 8: Know that suicide and self-harm will be issues

"In contrast to depressed persons who have relatively clear suicidal ideation, the [borderline's] self-mutilating behavior often serves to reduce guilt without death as an intent."⁷ However, the lack of impulse control exhibited by many borderline patients means that serious self-destructive behavior should be carefully evaluated because of the possibility that death will occur inadvertently. Patients' self-harm appears to be associated with guilt resulting from impulsive behaviors. Self-punishment is common in borderline patients and is considered the primary reason for self-harm and suicide.⁵ Self-mutilating behavior may be associated with a sense of psychological relief and often occurs after the patient has acted out or experienced a major interpersonal conflict.

Tolerating chronic suicidal thoughts is part of working with patients with BPD.¹¹ At least three fourths of borderline patients attempt suicide, and approximately 10% eventually succeed.¹¹ Patients with a concomitant depressive disorder have a nearly 15% to 20% rate of completed suicide.¹² Do not dismiss a patient's talk of suicide, but do remember that suicidal ideation and purposeful self-harm are ways in which borderline patients cope with their disorder. Additionally, almost no evidence suggests that hospitalizing patients with suicidal ideation prevents them from committing suicide.¹³ As

St. John states "if you are uncomfortable working with patients who acknowledge suicidal thoughts at nearly every visit, refer the [borderline] patient to someone else."⁶

CONCLUSION

Patients with BPD present a difficult challenge to clinicians, but the hard work of caring for these patients can pay off. The *DSM-IV* estimates that 5% to 10% of the general population has this "apparently common" condition² and that that number is about four-fold higher in primary care settings.¹⁴ These numbers seem to guarantee that primary care providers will have patients with BPD over the course of their careers. While the relationship has the potential to be tumultuous, having strategies for dealing with borderline patients can make all the difference. "As trying as it may be to have a borderline patient in a practice, and as slow as progress with the patient may be, successful management of such patients will add poise, confidence, and maturity to the exercise of invaluable primary care skills."¹

Research suggests that primary care clinicians have the skills needed to engage in the "constructive interdisciplinary management" of borderline patients.¹ If a patient is not currently in therapy or has previously resisted the idea of mental health services, the primary care clinician is well-positioned to create a functional and stable working relationship, characterized by a strong rapport, which may facilitate the patient's referral to and embracing of therapy. Given the borderline patient's sensitivity to perceived abandonment, the practitioner must present therapy as an adjunct to primary care and not as a replacement.⁵ Additionally, "by serving as a consistent, yet firm, [caregiver] who will 'call' the patient on his or her self-destructive behavior, the primary care [clinician] will be providing valuable psychosocial therapy."⁵ JAAPA

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