Dealing with borderline personality disorder

Original article: May Su

There is the hypothesis that borderline personality disorder may not be a true personality disorders but rather a form of post traumatic stress disorder. Regardless, a person with borderline personality disorder will present with particular characteristic traits which can be difficult to manage.

**Borderline personality disorder**

Characterized by: instability of mood, poor self-esteem and self-image, and poor impulse control (1). These mood fluctuations may occur over the space of hours or days, as opposed to the mood fluctuations that occur in bipolar affective disorder. There is often a great fear of abandonment, and higher sensitivity to rejection (or perceived rejection). This can manifest as more unstable interpersonal relationships. The term "splitting" refers to these intense by transient relationships, which can suddenly switch from idealization to contempt.

A person with borderline personality disorder can be incredibly charismatic and witty and enjoyable to be around. Beware of the patient who is overly effusive regarding your abilities. It can be a sign of splitting.

In the doctor-patient relationship splitting can be very problematic, as miscommunication is more like to occur in this setting. Team communication even to the point of regular case meetings, becomes even more important when "splitting" is occurring.

Patients with borderline personality disorder certainly have a higher rate of self-harm without suicidal intent, and in addition a higher rate of suicide attempts (unfortunately sometimes successful).

Epidemiologically borderline personality disorder is much more common in women (ratio of 4:1), and there is often a history of childhood trauma. It is difficult to make a diagnosis of borderline personality disorder prior to the age of 18 years, due to the other developmental changes occurring at this time. It is also extremely uncommon for a first diagnosis of borderline personality disorder after the age of 40 years. This may reflect the evolution of borderline personality disorder into more stable personality disorders, or it may mean that patients with borderline personality disorder may stop seeking help as they age.

**Techniques useful in dealing with the borderline personality disorder**

Historically, the treatment of patients with borderline personality disorder has been difficult (2).

The aim is to minimize and limit aggression and impulsivity via conflict resolution and psychotherapy. Limit setting is especially important in this setting. Be cautious of splitting.

Inpatient care is not generally indicated, unless there are clear cut treatment goals. There are concerns that prolonged inpatient stays can increase the risk of psychosocial dependence, and in fact increase the risk of regression, and thus self-harm. However there must be access to appropriate hospitalization for periods of severe regression or heightened suicide risk.
Things that can assist with inpatient care:

- Adequate communication between team members;
- if inpatient stay is required, there should be clear goals for why the person is admitted and a plan for when to discharge. Short stays are preferable;
- firm limit setting - verbal and physical abuse is never to be tolerated;
- be consistent - For example, if you have told the patient that they will have to have a "time out" for verbally abusing staff, then they must have a "time out";
- safety - removal of potential implements for self-harm;
- inform the community team on discharge, as the majority of care is often outpatient;
- it would also be helpful at this time to have a plan for further management, whether dialectic behaviour therapy, or for crisis intervention only.

The mainstay of treatment is long-term treatment with an appropriate therapist in individual and/or group psychotherapy.

**Dialectic behaviour therapy**

Dialectic behaviour therapy (DBT) is a modification of standard cognitive behavioural therapy, and was designed specifically for treatment for borderline personality disorder. Currently, DBT is the only therapy proven to be effective for treatment of BPD.

The focus of DBT is to teach patients 4 skills:

1. mindfulness (attention to one’s experience);
2. interpersonal effectiveness (predominantly assertiveness);
3. emotional regulation;
4. and distress tolerance without impulsivity.

The main difficulty is that the person has to be willing to change and able to interact with cognitive behavioural therapy.

**Limited value of medications**

Often by the time that a patient presents to a clinician that have often tried a myriad of therapies such as antidepressants or antipsychotics. Possibly there may be a faster response with concurrent therapy with dialectic behaviour therapy and treatments such as selective serotonin reuptake inhibitors (SSRIs), however there is limited benefit in treating BPD with medication alone.

Unfortunately there has been variable effectiveness with case management, and although certainly this can be helpful for some patients, it is not true for all.

**Reference articles**


(2) Finley-Belgrad E., Davies J. Personality Disorder: Borderline [electronic article]. *Emedicine.*
Last updated 3 May 2006. [Link]