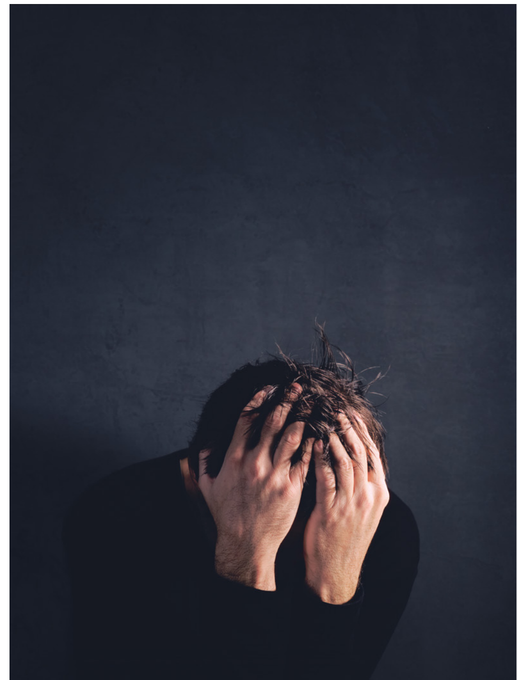
# Providing effective treatment for borderline personality disorder



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### Background
Borderline personality disorder (BPD) is a serious but treatable mental health condition with a good prognosis for those who access appropriate treatment. Early identification, provision of brief interventions and continuity of care aids remission, and is possible without general practitioners (GPs) getting burned out.

### Objective
This paper provides a brief overview of practical tips and useful resources for GPs to feel more equipped to provide effective care and support remission for individuals diagnosed with BPD.

### Discussion
People with BPD frequently present with complex problems and GPs can perceive patients as challenging to work with. It can be empowering for clinicians to consider a diagnosis of BPD when expectations of a challenging encounter occur. Early recognition and validation of underlying distress, psychoeducation and structured support can make a significant difference. Suicidal behaviour occurs in 80% of individuals with BPD, and they have a 20-year reduction in life expectancy, largely attributable to chronic diseases. This emphasises the importance of continuity in primary care.


**AMID SOARING RATES** of GP burnout[1] and an imbalanced compensation structure for extended consultations, the primary-care setting might seem ill-suited to detecting and managing complex mental health issues. Evidence underscores the value of GPs honing their skills in diagnosis and establishing trusting therapeutic relationships with patients with BPD. Psychological therapy is the evidence-based treatment. However, access to therapy and psychiatric care can be challenging. There is evidence that focused brief psychological interventions and sustained continuity of care delivered by GPs to patients with BPD can actively support remission and significantly curtail the premature mortality stemming from chronic conditions and suicide.[2,3] Where possible, working within a therapeutic team and developing confidence in identification of individuals at high risk and/or with more complex presentations who require psychiatric assessment, is encouraged.

## Identification

Identifying BPD requires a nuanced approach. It is frequently camouflaged by other conditions that can be difficult to identify and manage, including chronic pain,[4] mental health disorders (such as depression [see Box 1], anxiety, complex post-traumatic stress disorder), substance use,[5] disordered eating, gender dysphoria[6,7] and 'medically unexplained symptoms'.[8]

Overlooking BPD as a possible primary diagnosis and cause for challenges in the therapeutic relationship can result in medication misuse and care discontinuity, increasing risk of harm and chronic diseases. For GPs, expectations of a difficult encounter with a patient can signal the need to recognise a patient's underlying emotional pain and childhood trauma (when present).[9] This helps to differentiate 'difficult encounters' from 'difficult patients', improving identification and care.

Core features of BPD are outlined in Box 2. These patterns often emerge during adolescence. Given the recognised malleability of BPD traits at this developmental stage, early intervention programs have been demonstrated to reduce future morbidity and mortality.[2,10]

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**Box 1. Practice point**

Depressive symptoms require particular consideration because they are extremely common in BPD. GPs currently see and treat large numbers of patients with depression, successfully for the most part. However, when the course of the illness is atypical or patients do not improve as expected, it is important to consider an underlying diagnosis of BPD, especially if they present often, telephone often, and make increasing demands on care.

BPD, borderline personality disorder.

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**Box 2. Clinical features of BPD**

- Identity disturbances with fragile, unstable sense of self and chronic sense of emptiness
- Pervasive unstable relationships that are characterised by switching from idealisation to devaluation, usually in reaction to feeling criticised or rejected
- Intense fear of abandonment or rejection by others
- Emotional instability with intense and changeable emotions that are poorly regulated
- Intense anger and difficulty controlling it
- Impulsive behaviours and recurrent self-harm using multiple means including NSSI, substance use, disordered eating, unsafe sex and other risk-taking behaviours
- Chronic suicidal thoughts often accompanied by suicidal threats or behaviour
- Stress-related paranoid ideation and dissociative symptoms

BPD, borderline personality disorder; NSSI, non-suicidal self-injury.

Adapted by Beatson J and Rao S from The Diagnostic and Statistical Manual of Mental Disorders, 5th edition. American Psychiatric Association, 2013.

**Box 3. Therapeutic elements foundational for effective treatment of BPD**

1. Respect and empathy
2. Support and validation of distress
3. An active, collaborative, interested stance
4. Focus on the patient's mind and affect rather than on their behaviour
5. Consistency and reliability
6. Clarity about the limits of what the GP can do, when and if required
7. Clarity about treatment boundaries
8. Clarity about limits for disruptive behaviours
9. Willingness to discuss misunderstandings or other disruptions that arise and take responsibility for one's own part in what has occurred
10. Awareness that use of medication should be adjunctive; used only for treatment of symptoms; ceased as soon as possible

BPD, borderline personality disorder; GP, general practitioner.

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## Treatment principles

The term 'disordered personality' might be perceived to be stigmatising and suggests a static and unchangeable condition.

BPD is, in itself, treatable with psychological therapy. Severe symptoms necessitate specialist psychological treatment, preferably as part of a therapeutic team with the individual's GP. Individuals with less complex presentations can greatly benefit solely from a therapeutic relationship with their GP.[2,10,11]

Individuals with BPD often face judgment and rejection, making it difficult for them to adhere to treatment plans and to trust validation and being taken seriously. For new patients, booking regular review appointments and collaboratively defining the agenda for each consultation can be beneficial. Collaborative work with patients to create a 'safe space' that is trauma-informed, validating and empathetic, with clear communication to set realistic expectations, can support a continuous therapeutic relationship that is crucial for navigating the recovery process and to lay the groundwork for remission. The common therapeutic elements that are the foundation for BPD treatment (Box 3) can be readily implemented by GPs.

## 10 treatment principles for BPD in primary care

The following 10 treatment principles are designed for primary-care settings, guiding brief interventions in the time constraints of a busy general practice. Built on the foundation of therapeutic elements common to effective treatments for BPD (Box 3), they are suitable for any GP, ideally as part of a therapeutic team, but also where there are challenges accessing psychologists and psychiatrists.

### 1. Diagnosis

Identify patterns of unstable relationships, self-image and affect, and reflect on expectations of challenging encounters to flag need for further assessment. McLean[12] and BPQ[13] are useful screening tools to create a starting point for psychoeducation if a high likelihood of BPD is identified (see 'Useful resources').

### 2. Psychoeducation

Educate patients about their diagnosis, with emphasis on effective treatments. Recommend resources such as Sane and Project Air factsheets (see 'Useful resources').

### 3. Safe space

Ensure a validating, empathetic and trauma-informed environment, with clear communication about therapeutic boundaries.

### 4. Regulation of emotions

Help patients to become aware of intense emotions, identify triggers and implement strategies to reduce acting on triggers.

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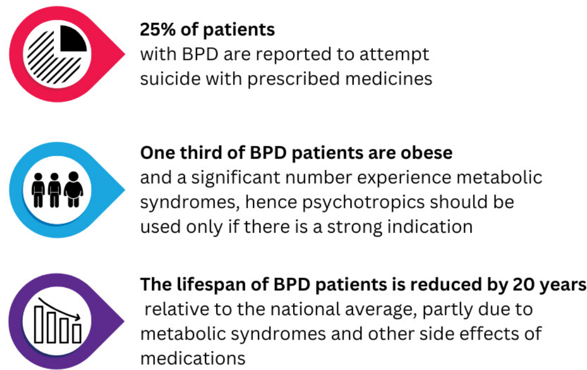


**Figure 1.** Rationale for prescribing caution in BPD.

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### 5. Focused brief psychological interventions

Focused brief psychological interventions, for example structured problem solving, relaxation strategies, sleep-hygiene education, motivational interviewing regarding concomitant substance use, cognitive or dialectical behaviour therapy or acceptance and commitment therapy, can be used to deal with current problems as identified by the patient.

### 6. Prescribing caution

Be wary of prescribing psychotropics and sedatives, given the overdose risk[14] (Figure 1). Medications should not be used as primary treatment as there is no evidence of efficacy but they might play these roles:

- management of crisis, with short-term and low-dose quetiapine or olanzapine, which would typically be a non-Pharmaceutical Benefits Scheme prescription
- treatment of co-occurring psychiatric conditions (depression not responsive to psychotherapy or with psychotic features and bipolar disorders)
- targeting specific symptoms (eg significant anger or aggression, micro-psychosis triggered by stress)[15]
- the use of omega-3 fatty acids to reduce aggression and improve depressive symptoms per some small studies.[16]

If prescribing, consider a low dose of a single medication in small quantities, for limited periods.[17,18] If ongoing medication is prescribed, psychiatric review is strongly encouraged.

### 7. Advocate

GPs can advocate for access to appropriate therapeutic services and for psychiatric opinions where there is diagnostic uncertainty, complexity or concern regarding risk.

### 8. Collaborative planning

Establish a joint treatment and crisis plan and communicate regularly with health providers and other supports to avoid splitting. Involve family members and/or carers identified by the individual. Consider supports and resources that carers might need.

### 9. Continuity of holistic care

Prioritise chronic disease prevention and age-risk-based screening.

### 10. Self-reflection and self-care

Recognise signs of vicarious trauma, burnout and compassion fatigue in yourself, particularly when managing chronic suicidality. Agree on clear limits for disruptive behaviours and about treatment boundaries. Seek mentoring, consider a Balint group and prioritise self-care.

## Suicidality assessment tips

Chronic suicidality is a diagnostic feature of BPD. The fear of losing a patient to suicide creates significant anxiety for health professionals with 10% of BPD patients dying by suicide.[19]

Acute suicidality needs to be differentiated from chronic suicidality. Chronic suicidality is characteristic of BPD; it helps the person with BPD to communicate their distress and seek help. It is not usually intended to result in death. Many patients with BPD have lived with chronic suicidality for several years and they recover from it when BPD goes into remission. Box 4 provides a summary of assessment and risk-management strategies.

When assessing risk of suicide (men and women are equally represented in coronial data), the following factors are associated with increased risk:[19–21]

- Concurrent mental health diagnosis, eg psychosis, depression, antisocial personality disorder, worsening substance use.
- Recent change in symptoms, eg severe regression, prolonged dissociation.
- History of high impulsivity and/or high-lethality suicide attempts.
- Change in pattern of self-injury, and access to means (eg medication).
- History of sexual abuse.

Differentiating between suicide attempts and non-suicidal self-injury (NSSI) can be challenging. Within a strong therapeutic relationship and with knowledge of the right risk assessment questions, confidence can be enhanced. This paves the way for transparent and empathic conversations. NSSI occurs in 85% of patients with BPD.[20] It is typically a reflection of intense emotional pain and a need to be heard and taken seriously.[22] NSSI has a soothing effect via the release of endorphins.[23] Over time healthier strategies to soothe psychological distress should be encouraged. Although an exact risk assessment might appear challenging, the process can become more instinctive and clear-cut within a long-term therapeutic relationship.

## Managing NSSI

Common forms of NSSI in individuals with a BPD diagnosis include cutting, bruising, burning, head banging, biting, overdosing on medications and food restriction. When patients present after injuring themselves, it can be useful to use the following principles:

- Identify triggers: understand the event and the underlying emotional cause, whether it is rejection, loss or failure.
- Empathy: address and validate the distress without fixating on the self-injury act.
- Encourage self-management: if feasible, teach the individual to care for their


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injuries and recognise when they need to seek medical attention.
- Psychotherapy: can significantly diminish NSSI episodes.

### Essential continuity of care

Individuals with BPD have a higher likelihood of obesity, hypertension, metabolic syndrome and polycystic ovarian syndrome.[24] For some, use of long-term antipsychotic medications can further increase risk. Chronic pain syndromes[4] and substance use[5] are other common comorbidities. Establishing consistent care that offers ongoing primary and secondary prevention is pivotal to deter the emergence or escalation of chronic diseases.[25]

**Box 4. Overview of suicidality assessment and management strategies for BPD**

- Look for changes in patterns of risk behaviours and potential lethality of and access to methods. Understand reasons for escalation of risk (refer to Figure 2)
- Consider history of high-lethality and/or high-impulsivity attempts as well as whether there has been a recent change in symptoms and/or life circumstances
- Help the patient understand the triggers and emotional dynamics that have resulted in any recent escalation
- Problem-solve with the patient. Teach emotional regulation skills
- If clinicians cannot tolerate suicidality, patients get more frightened. Discuss with patients what might help them
- Validate emotional pain/hopelessness of the situation from the patient's point of view
- Express hope and optimism, but do not become a 'cheerleader'. Try to avoid getting into a debate where the patient is for death and you are for living
- Consider admission if acute high risk is identified. Sometimes it is lifesaving. However, avoid routine hospitalisations
- Be aware of over-reaction versus under-reaction on your part. Involve family, friends, and partners with consent where possible
- Document your treatment plans carefully. Consult colleagues and seek supervision. Follow up closely with the patient

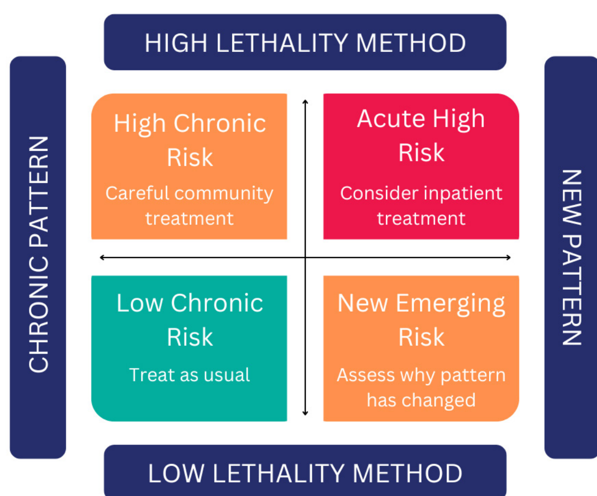


**Figure 2.** Matrix method of risk analysis.[14,26]

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## Conclusion

BPD is a treatable condition. Psychological therapy is effective in improving outcomes. Recognising the high prevalence of BPD and risk of significant morbidity and mortality, the provision of brief interventions and continuity of non-judgmental, trauma-informed, and compassionate care by GPs to BPD patients optimises their potential for remission and leads to healthier and more fulfilling lives. This article provides only a brief overview of the key principles in providing care to individuals living with BPD. GPs interested in applying the therapeutic elements and 10 principles outlined here are encouraged to undertake further reading into the details of this approach (see 'Useful resources').

## Useful resources

### Books and screening instruments

- Beatson J, Rao S, editors. Spectrum Personality Disorder Service, Borderline personality disorder: A practical guide for general practitioners, www.eventbrite.com.au/e/book-only-bpd-a-practical-guide-for-general-practitioners-tickets-1096896409689
- Poreh A. Borderline Personality Questionnaire (BPQ), www.academia.edu/9330762/BPQ_Borderline_Personality_Questionnaire
- Zanarini MC, Vujanovic AA, Parachini EA, Boulanger JL, Frankenburg FR, Hennen J. A Screening measure for BPD: The McLean screening instrument for borderline personality disorder (MSI-BPD), https://guilfordjournals.com/doi/10.1521/pedi.17.6.568.25355

### Carer resources

- Australian BPD Foundation Limited, Resources for carers, www.bpdfoundation.org.au/carers.php
- Spectrum Personality Disorder Service, Information for families and friends (carers), www.spectrumbpd.com.au/information-resources/information-for-families-friends-carers

### GP support

- Balint Society of Australia and New Zealand, Clinical reflective practice for health professionals, https://balintanz.org
- Black Dog Institute, The Essential

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Network (TEN) resources and support for burnout, www.blackdoginstitute.org.au/the-essential-network
- DRS4DRS, Health-related resources, tools and information, www.drs4drs.com.au/resources
- The Royal Australian College of General Practitioners (RACGP), The GP support program, www.racgp.org.au/running-a-practice/practice-management/gp-wellbeing/the-gp-support-program

### Patient factsheets

- Sane, Borderline personality disorder (BPD) factsheet, www.sane.org/information-and-resources/facts-and-guides/borderline-personality-disorder#factsheet
- University of Wollongong, Project Air fact sheets, www.uow.edu.au/project-air/resources/fact-sheets

## Key points

- BPD affects up to 6% of primary-care patients and, for most, this diagnosis is camouflaged by comorbidities.
- BPD is treatable.
- There are 10 treatment principles that can readily be applied in primary care, including creating a safe space, psychoeducation, brief focused psychological interventions, advocacy and collaboration.
- Gaining confidence in distinguishing acute from chronic suicidality and suicide attempts from NSSI is an important area of focus.
- GP continuity of care is essential to address increased prevalence of chronic disease, and reduced life expectancy.

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Competing interests: GS was the recipient of the RACGP Foundation/HCF Research Foundation 2023 grant, of which there is no conflict with this paper. The content within this article corresponds with the recommendations outlined in the guidelines 'Borderline Personality Disorder: A practical guide for general practitioners', edited by JB and SR, published in 2020 by Spectrum Personality Disorder Service. The authors of this article were contributors to the development of these guidelines. All proceeds generated from the sale of these guidelines support Spectrum Personality Disorder Service, a not-for-profit organisation and statewide service of Eastern Health, Victoria.

Funding: None.

Provenance and peer review: Not commissioned, externally peer reviewed.

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### Acknowledgement

Ms Dimitra Petroulias for her role in coordinating and providing assistance with editing this paper.

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