Borderline Personality Disorder in Primary Care

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Management of borderline patients requires skills that are at the heart of successful continuity of care. These skills include alliance-building, educating patients about their symptoms, referral, encouraging communication and cooperation in the health care team, utilizing community resources to sustain one's own professional development, and foreseeing and preventing morbidity. 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 these invaluable primary care skills.

More clinical and empirical discussion of borderline personality disorder is needed in the family practice literature. Probably no other professional is more likely to see such patients. The informed, motivated family physician, with the help of a supportive multidisciplinary team, can make invaluable contributions to reducing morbidity in borderline patients and can help avoid misunderstanding, frustration, and exhaustion in the health care team of the patient with this challenging disorder. **J FAM PRACT 1990; 30:329-335**

Patients with borderline personality disorder (BPD) are said to be attracted to medical settings. They are also thought to be overtly or covertly demanding of their primary physician, and difficult to refer to a psychotherapist because of their need to define their problems in concrete and physical terms. They find ways of receiving expensive but unnecessary tests, are noncompliant, and manipulate providers in ways that can create hard feelings among the health care team.[1-4] Unfortunately, evidence for such reports is not empirically based but largely anecdotal and borrowed from observations made in mental health settings.

Empirical research is needed to provide primary physicians with a stronger basis for management of these often difficult patients. Because they often resist psychological conceptualization of their health problems, patients with BPD may be encountered more often in primary care practices than in psychological settings. The type and frequency of symptoms manifested by such patients in the primary care setting are not yet entirely clear, but these patients appear to display a high degree of somatization. The emotional and financial repercussions from patients with BPD on the health care system are not yet well researched, but such patients probably cost the system less when they are maintained with the help of a primary physician than when they are not.

Recently, improved consensus about the diagnostic criteria for BPD[5,6] has made empirically based research on the disorder more feasible and meaningful. Research in psychological settings has progressed rapidly. In some cases, improved understanding of BPD by professionals in the mental health care system has led to increased resistance to the unpleasant feelings that patients with this disorder frequently elicit in their caregivers, more rapid and more certain diagnosis, better understanding of how and why the disorder is manifest in the patient, more realistic treatment goals, improved management strategies, and improved morale in the treatment team.

Knowledge of the natural history and long-term outlook for any disorder is especially important for the primary care physician. Until recently, almost no such research was available on BPD, which probably accounts for the disorder having been so often overlooked in primary care literature (there are a few exceptions[1]). Fortunately, recent research does provide some insight into the natural history of BPD.[7]

It now appears that primary care physicians possess professional skills applicable to constructive interdisciplinary management of patients with BPD. Clinical review of

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BPD phenomena and treatment dilemmas is timely and may encourage further research on the prevalance and manifestations of the disorder in the primary care setting.

MAKING THE FORMAL DIAGNOSIS

The two leading psychometric systems applicable to BPD, Diagnostic and Statistical Manual, ed 3, revised (DSM-III-R), and Gunderson's Diagnostic Interviews for Borderline Patients,[8] are similar. DSM-III-R suggests that at least five of the following behavioral features should be apparent: (1) impulsivity (including tendencies to sexual acting out, substance abuse, overeating, shoplifting, or shopping binges); (2) intense, unstable interpersonal relationships (often featuring entitlement, manipulation, devaluation, or intense dependency); (3) difficulty in the regulation and appropriate use of anger; (4) unstable self-image; (5) unstable mood; (6) difficulty in accepting loss or being alone; (7) a tendency toward physically self-damaging acts (eg, self-mutilation, suicidal gestures, recurrent fights or accidents); and (8) a recurrent tendency toward feelings of boredom or emptiness.[6]

Gunderson's system also includes a history of transient psychotic episodes, eg, temporary periods of derealization, depersonalization, paranoia, psychotic depression, or severe regression, sometimes stimulated by substance abuse or by hospitalization.[8]

By objectively recording the actual criteria used to make the diagnosis in a patient's chart, the physician encourages reliable and consistent use of the term. Other professionals will then know which dimensions of borderline behavior most characterize the patient.

Dynamics and Informal Diagnostic Indicators

The new research on the natural history of the disorder has yielded a tentative picture of the developmental history and dynamics. By understanding these dynamics, the physician can utilize informal indicators to prompt consideration of the more formal diagnosis.

Early recognition can be useful. The diagnosis is often first suspected from observations accumulated over time, as the physician gradually ascertains a patient's style of interaction with providers and family. (In contrast, a diagnosis such as depression can often be made from review of relatively easily reported symptoms.)

Patients with BPD often (but not always) come from families in which early abuse, loss, neglect, parental dysfunction, enmeshment, and other severe disturbances make consistent and sound family homeostasis impossible.[9-12] Sexual victimization appears to be an especially common theme. Distinguishing between BPD and post-traumatic stress disorder resulting from early sexual victimization can be difficult or impossible,[10-13] but the nature and natural history of post-traumatic stress disorder originating in childhood is not yet fully understood.[14] Early sexual abuse appears to predispose victims to other psychological disorders as well.[13]

Perhaps because their families of origin could not provide a base for sound early development, many borderline patients have not learned to trust their own inherent resources or the offerings of others in building social alliances. Because their experiences in past relationships of continuity have often been intensely disappointing, borderline patients may only be able to base models of continuity relationship on fantasies or fears. Their fantasies are apt to include an unverbalized assumption that to avoid past disappointments, both partners of an enduring relationship must mobilize vast amounts of emotional energy and be prepared for untold sacrifice to make the relationship trustable. As patients with BPD have not learned to adapt to mild or moderate degrees of disappointment, any frustration of hopes or expectations about a potential caring relationship can be a major blow.

Because of a lack of previous successful continuity relationships, the patient with BPD is usually poorly prepared to understand the nature of the social contact on which good primary medical care is predicated. Thus, one informal indicator of BPD in a patient is a relationship with the primary health care team that always seems fragile, stormy, or inappropriate.

Perhaps also because of social disappointments during early childhood, borderline patients are sensitive to the threat of personal abandonment and to disturbances that can accompany loss and change in the social network. Any change in the normal family pattern can be sufficiently disturbing to cause a marked decline in personal functioning. When one family member seems stressed well beyond what would normally be expected by a change in family structure and functioning, the physician may suspect a vulnerability to BPD disorder in that patient. Borderline patients also tend to be exquisitely sensitive to loss or change in the health care team, as discussed more fully below.

Probably because of these same early disappointments, patients with BPD are apt to respond with fears of abandonment and rejection to almost anything their physician recommends (eg, a referral). Because they have difficulty with uncertainty and abstraction, they can also be disturbed by vague explanations (eg, "It's in your head"), and may search for an unambiguous, all-healing, rapid solution to their problem that they can literally hold (eg, a pill). If given medication, however, they often have untoward reactions or are non-adherent with medication instructions. Patients with BPD are also prone to seize on

quack remedies that appeal to their need for the concrete and unambiguous.

A borderline patient will sometimes hate at least one member of his or her health care team.[15] Most patients who falsely accuse providers of sexual improprities are borderline.[16] More generally, the diagnosis of BPD may be worth pursuing with any patient who seems to evoke intense dilemmas around the management of his or her neediness, manipulativeness, mistrust, anger, masochism, inconsistency, or unreliability.

Patients with BPD are well known for provoking extreme and incompatible responses in their treatment team. Such reactions also often reveal much about the psychological makeup of members of the team. For example, a borderline patient is likely to elicit strong boundary setting and resistance to manipulation by a provider who has trouble accepting internally generated dependency needs. On the other hand, a team member who has trouble accepting internally arising aggressive impulses is likely to see the borderline patient as emotionally orphaned and in need of nurturance.[3] Successful treatment of a borderline patient may involve maturation of the treatment team as well as the patient. For example, hard-line limit setters on the team may learn some understanding and patience, and nurturers may strengthen useful personal skills in limit setting.

Borderline patients frequently polarize everything around them, including the "goodness" and "badness" of people. They are likely to present themselves 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. One can suspect a patient with BPD when staff are divided and distrustful of each other over a patient's care, often as a result of a team member accepting at face value the patient's polarized experience of the world.

Finally, it is often noted that patients with BPD are attracted to the care, structure, and drama of medical situations. They are drawn to this environment both as patients and as a career choice.[3] It is now well recognized that BPD underlies the majority of cases of Munchausen's syndrome.[17,18] (Furthermore, it appears that most Munchausen's patients are themselves health care providers.[19]) Intense, masochistic, and aberrant needs to care and be cared for are further informal indicators for considering the diagnosis.

LONG-TERM PROGNOSIS

Ten- to 15-year follow-up studies of borderline patients are becoming available. Most of these studies have been done on patients who were at one time in private mental hospitals. One study is available, however, with a sample from a public hospital serving a broad catchment area.[20] In this study active symptomatology of most patients with BPD was found to decrease at follow-up. In many cases the disorder remitted to the degree that the symptoms no longer met diagnostic criteria for BPD. Even among those in the improved group, however, significant dysfunction in interpersonal relations and in productivity was still apparent. The average follow-up score on the Health-Sickness Rating Scale was 63 out of a possible 100, indicating that the patient was "generally functioning well but still had a focalized problem or more generalized lack of effectiveness without specific symptoms."[21]

Patients with BPD may be functioning at their optimum, even when they seem to lack self-definition and do not seem to be especially close to anyone, productive at work, or free from a feeling of emptiness. They are more prone to impulsive, near-psychotic, and self-destructive behavior at times of change and uncertainty in their family functioning and in their arrangements for professional care. At these times, the primary physician and other members of the team should be especially alert to exacerbations of the disorder. For many patients, prevention of morbidity during these times will be a more realistic treatment goal than cure of the underlying disorder. A lasting longitudinal perspective on management appears to offer important advantages, especially when it is supplemented appropriately and promptly with more specialized care during times of change and of flare-up of dangerous aspects of BPD.

Prediction of Suicide

A follow-up study of borderline patients and other recent similar studies indicate that suicide risk over a 10- to 15-year period is between 3% and 9%.[22-24] A history of earlier suicide attempts increases the likelihood of subsequent suicide.[24] These data destroy a common myth that suicide attempts in patients with BPD are largely feigned for manipulation and attention. Discounting suicide threats or gestures in a borderline patient can lead to a failure to insist on psychiatric hospitalization when it should be done. Responding as though the pain, frustration, and urges to self-destruction are not real can foster problematic and painful feelings of rejection and abandonment in that patient.

PHYSICIAN-PATIENT ALLIANCE

Patients with BPD often operate at the fringes of what the primary physician can tolerate in terms of tenuous, unusual, or intense alliances. It is difficult but important to

attempt to engage such patients in a sound and lasting physician-patient alliance.

Borderline patients can be especially impulsive and elusive in how they let their physician know about key aspects of their psychopathology. For example, a patient prone to substance abuse binges may let a primary physician know about the problem with a late night telephone call while "under the influence" and then neglect follow-up appointments for office discussion of these matters. Less seriously impaired patients may be able to bring up critical matters only at the very end of scheduled appointments. Such patients can respond well in the long run to keeping telephone calls brief and simple, and to patient encouragement to discuss emotionally charged matters in timely fashion during regularly scheduled office time.

Borderline patients can make other surprising and troublesome attempts to intensify the physician-patient relationship, including excessive and inappropriate gifts. A provider may be surprised by a borderline patient who announces that she has initiated a pregnancy because she has noticed how much the physician enjoys children. It can be difficult to let such a patient know that having a baby will not change the provider's attitude toward her, and to give her room to decide whether she wants the baby for herself.

Other ingenious patients with BPD attempt to gain control of the physician-patient relationship by determining the criteria that will justify scheduling an emergency visit and then frequently presenting to the physician's office with complaints matching these criteria. Such patients can exhaust great amounts of professional energy, time, and resources.

To build a lasting physician-patient alliance, the physician must consider the physician's own needs as well as the patient's. Self-interest on the part of the physician can actually be reassuring to a borderline patient whose previous caretakers have fallen under the weight of the patient's dependency needs. Fair and realistic provision for the physician's self-interest may even help the patient gradually move toward a relationship somewhere between unrealistic expectations of perfection and deep disappointment, and between isolation and dependency, which has been elusive in the past. Such self-interest on the part of the physician should include maintenance of appropriate time and financial boundaries and a professional and objective attitude.

Patients with BPD may especially benefit from an alliance that avoids extremes of constant availability or harsh limit setting. Offering the opportunity to a borderline patient to work toward a realistic alliance is bound to be challenging to both physician and patient (it is possible for borderline patients to learn from such an offer even should they refuse it); not offering may adversely affect any other treatment the primary physician attempts to provide.

MULTIDISCIPLINARY TREATMENT

It is difficult to refer the patient with BPD to another professional without raising fear of rejection in the patient. The patient may not be able to verbalize this fear, but instead may act it out in self-destructive ways. Such a patient can respond well to assurances that the physician is not abandoning the patient just because the physician is asking for help from other specialists.

The family physician's interdisciplinary management skills can be especially useful in the care of the borderline patient, as sound interdisciplinary communication and mutual support appear essential to effective treatment. Because such patients can be so demanding and manipulative, the physician needs to be alert to the psychological state of the other team members as well as the patient. A treatment team member having difficulty in working through frustration, anger, or exhaustion is a signal for increased communication, teamwork, and understanding.

Even poorly functioning patients with BPD may be maintained fairly well with long-term professional support that can provide medical care, psychiatric hospitalization, alcohol and psychoactive drug management, individual and family therapy, and social work assistance in a coordinated manner.[3] Team effort benefits the providers as well, particularly in providing mutual support that protects against individual exhaustion. Team members can also develop a more rounded picture of the patient.

PREVENTION OF MORBIDITY AND MORTALITY

Doherty and Baird[25] have beautifully illustrated how family physicians are becoming increasingly sophisticated at recognizing and managing dysfunction arising from disturbances in social homeostasis. This approach is very useful with the borderline patient. By watching for disturbances in the patient's social network likely to accentuate BPD psychopathology, the physician can decrease the morbidity and mortality resulting from the disorder.[26,27] Although most patients are likely to feel less well during disruptions in family functioning, perhaps no other psychologically disordered patient responds so dysfunctionally to such conditions.

At times of social network disturbance, patients with BPD may attempt to manipulate the legal or welfare system through the physician. For example, a handicapped borderline patient with a decubitus may severely self-mutilate the ulcer just as a family member is to be imprisoned, hoping the judge will decide the family member needs to stay at home to care for the patient. Once the intense fears about impending separation are understood,

the borderline patient may respond positively to a program geared to keeping the patient healthy enough to visit and help the family member in jail.

One inevitably difficult transition for patients with BPD occurs when they must change physicians, as for example, when their family practice resident graduates and a new resident is assigned. At least some acting out can be expected at this time. Patients will often show long-term progress to the ongoing members of the health care team, usually because the patients are able to talk more about their feelings about a departure and show less intense psychopathology than during earlier changes.

Improved resident morale in the UCSF/Fresno Family Practice Program has resulted from an even allocation of borderline patients to junior residents when the senior residents graduate. This approach also encourages resident-to-resident cooperation and information exchange during the transition.

The most common failures in health care for patients with BPD who depend on publicly funded care probably are lack of continuity in treating personnel and lack of careful preparation for provider transition.

The Family of the Borderline Patient

Physicians can indirectly assist the patient with BPD through support for family members and friends. Physicians can also at times assist the borderline patient by referring the family to appropriate premarital counseling, prenatal counseling, parenting classes, support groups for families of substance abusers, or child protective services; such assistance can help the family develop emotional resilience and a clearer and stronger structure for prevention of abuse and other forms of dysfunction, particularly during family transitions. Borderline patients appear to especially profit from stable and strong continuity of contact with family and friends. Schneiderman[28] has movingly illustrated the key role played by the support provided by the family and friends of Samuel Beckett, who was, according to Schneiderman, one of the more famous persons with BPD in the 20th century.

Medication

While BPD itself probably cannot be treated with medication, exacerbations of symptoms in the form of clinical depression, transient psychosis, or intense anxiety sometimes can be treated.[27-29] The multiaxial system of DSM-III-R[6] can be useful when detailing medication decisions. Recent difficulties with physical disorders (axis III), of which the family physician is usually especially aware, and psychosocial stress (axis IV) can increase the likelihood of exacerbations of acute symptoms (axis I) in the borderline patient. Knowledge of highest recent functioning (axis V) can be useful in gauging when a patient with BPD has returned to a baseline state and thus may no longer require medication. The physician should not expect the medication to change deeper character structure and should not give the impression that the medication is a punishment.

Supporting the Borderline Patient's Ego

A nonconfrontational and educational approach toward somatization, anger, rules about calls and visits, and acting out is probably wise. Borderline patients often lack the capacity to profit from therapeutic interpretation, catharsis, or corrective experience.[3] Many family physicians do not realize this problem, and inappropriately try confronting borderline patients with vague and premature interpretations (eg, "Your symptoms are actually due to stress").

After some semblance of a physician-patient alliance has been formed, one potentially therapeutic maneuver involves gradually encouraging the patient's abilities in self-observation, self-inquiry, and delay of action (eg, the family physician who has slowly, patiently, and firmly helped a patient learn to talk about substance abuse when the patient is not on a binge and has not brought up the problem during the last minute of a scheduled appointment). This supportive approach may eventually lead patients to develop far more specific, accurate, and well-timed interpretations for themselves than any the physician could supply through confrontation. Encouraging patients to talk about the problem in the context of constructive alliance building is necessary for this maneuver to work.

A knowledge of the early natural history of the disorder can sometimes provide a useful framework for physician, treatment team, and finally the patient to understand some of the more puzzling and difficult aspects of the disorder, particularly when traumatic victimization has played an important role in the cause of the disorder. Since the relevant memories will be intensely painful for the patient, however, the physician should not press this framework of understanding on the patient.

WHAT CAN THE PRIMARY PHYSICIAN GAIN?

Almost all commentators on BPD agree that patients with this disorder are particularly adept at exposing and testing any psychoemotional weaknesses the provider brings to patient care. There are no simple maxims, no procedures, and no known medications behind which the physician with a borderline patient can hide. Any provider can

expect his or her management skills to be tested by encounters with borderline patients. The wise primary physician may be able to profit from the borderline patient's visit by staying alert to ways the framework and the skills the provider brings to patient care might be strengthened. Even if care for many borderline patients is geared more toward preventing morbidity than accelerating cure, caring for such patients can be extremely rewarding because there is often much to be learned from the experience about one's own self as a professional.

While the number of patients with BPD in a practice are usually few, there are often many patients who, because of disappointing experiences with earlier caretakers, bring to the primary care setting some degree of mistrust, unfulfilled or exaggerated hope, a need for lucid education about the nature of the physician-patient primary care relationship, or difficulty in knowing when and how to talk about emotionally significant issues. Learning to maintain a sense of professional reliability, balance, and perspective while dealing with a borderline patient can improve the approach brought to the care of these impaired patients.

Some hear echoes at a broader social level of the borderline patient's feelings of emptiness, helplessness, and failed efforts at finding self-definition. Many patients who do not have BPD still may have experienced some similar feelings, particularly if they have been victims of the wars, genocides, despoliation of the environment, social injustices and disruptions, crimes, and other events that have too often fractured the sense of self, family, and community in the 20th century. Learning to deal with borderline patients helps physicians learn to develop a therapeutic approach to dealing with others less severely impaired but still touched by the social traumas of the times.

WHAT CAN THE HEALTH CARE TEAM GAIN?

The patient with BPD may also enrich the health care team by serving as an impetus to derive and provide more constructive mutual support within the professional community. Optimal learning from working with a borderline patient results from a multidisciplinary team effort.[3,30,31] Balint groups, talking with a psychotherapist about borderline patients, and team meetings for coordination of care can all help the team capitalize on the learning opportunities that are almost always inherent in the care of a patient with BPD.

Just as successful management of a borderline patient will strengthen the individual physician's composure and confidence, so will a successful team effort in dealing with a borderline patient improve communication, sensitivity, resilience, and confidence in the health care team. Regardless of whether borderline patients improve, their care often serves as a potent impetus to the health care team to improve their own services. Care for the patient with BPD can encourage, for example, clearer, fuller communication and clarification of role expectations between physician and screening nurse, among members of a call group, between physician and clinic administrators, between physician and local substance abuse teams, and between the physician and the patient's psychotherapist. The family physician can play a key role in helping the team improve, grow, and mature. Without informed guidance, the result can be disintegration, isolation, and frustration for the health care team as well as the borderline patient.

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