Approach to Borderline Personality Disorder in Primary Care

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Disclosure

- Presenter: Eytan Perl, MD FRCPC

- I have no conflict of interest to report, and no relationship with commercial interests

Objectives

- Provide an overview of the basic epidemiology, diagnostic criteria, and theoretical etiology of Borderline Personality Disorder
- Review important components of psychoeducation
- Discuss a general approach to clinical management of patients with borderline pathology
- Discuss principles of managing suicidality and self-harm behaviour
- Discuss an approach to pharmacologic management of borderline symptoms

Presentation in Family Practice

Diagnosis

- **Core Feature:** Pervasive pattern of instability of interpersonal relationships, self-image, affects, and impulsivity

Interpersonal Hypersensitivity*

- **Abandonment fears**
- **Unstable relationships** (idealizing/devaluing)
- Chronic feelings of emptiness

Affective/Emotional Dysregulation

- **Mood/affective instability**
- **Inappropriate, intense anger**

Behavioural Dyscontrol

- **Recurrent suicidality, threats, self-harm**
- **Impulsivity (substance use, sex, bingeing, driving, etc)**

Disturbed cognitions/identity

- Unstable/distorted self-image
- Depersonalization, paranoia/transient psychotic symptoms while distressed

Epidemiology

- **~1 - 2% in general population**
- **~6% in primary care; 1 in every 16 clinic visits**
- Suicide rate: 8% - 10% (**50x the general population**)
- Suicidal behaviour: 60% - 80%
- Highest risk in young adult years
  - Late teens to late 20’s
- Early all cause mortality
  - 18% by age 65

Psychiatric Comorbidities

- MDD
- Anxiety Disorders (GAD, Social Anxiety Disorder)
- Bipolar D/O
- Eating Disorders (particularly bulimia)
- PTSD
- Substance Use Disorders
- ADHD
- Other PD’s

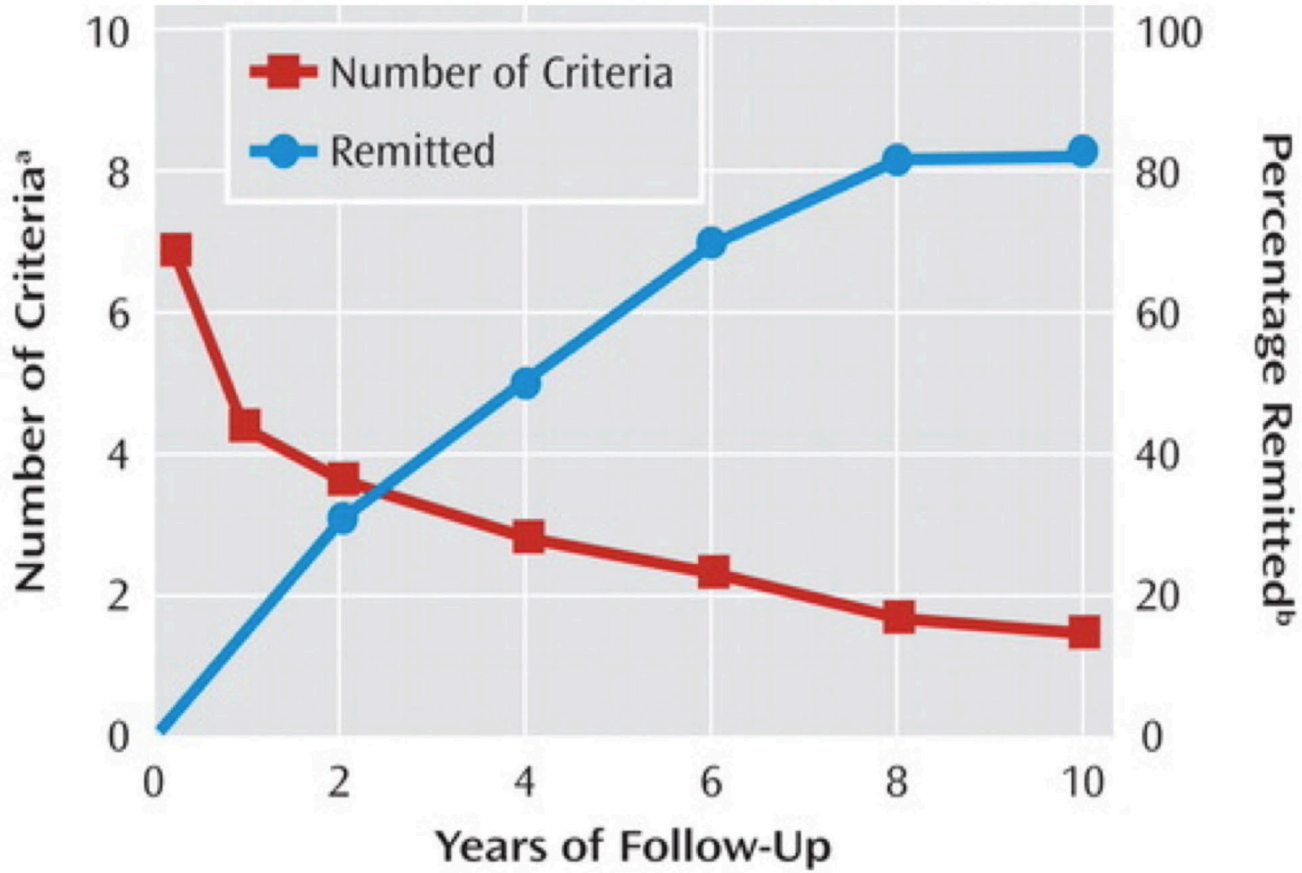
Other Medical Comorbidities

- Diabetes
- Osteoarthritis
- Obesity
- Urinary incontinence
- Overall poorer health habits
  - Higher rates of smoking or drinking EtOH, less frequent exercise
- Pain disorders
  - Fibromyalgia, nonspecific back pain, TMJ disorder, migraines

Etiology

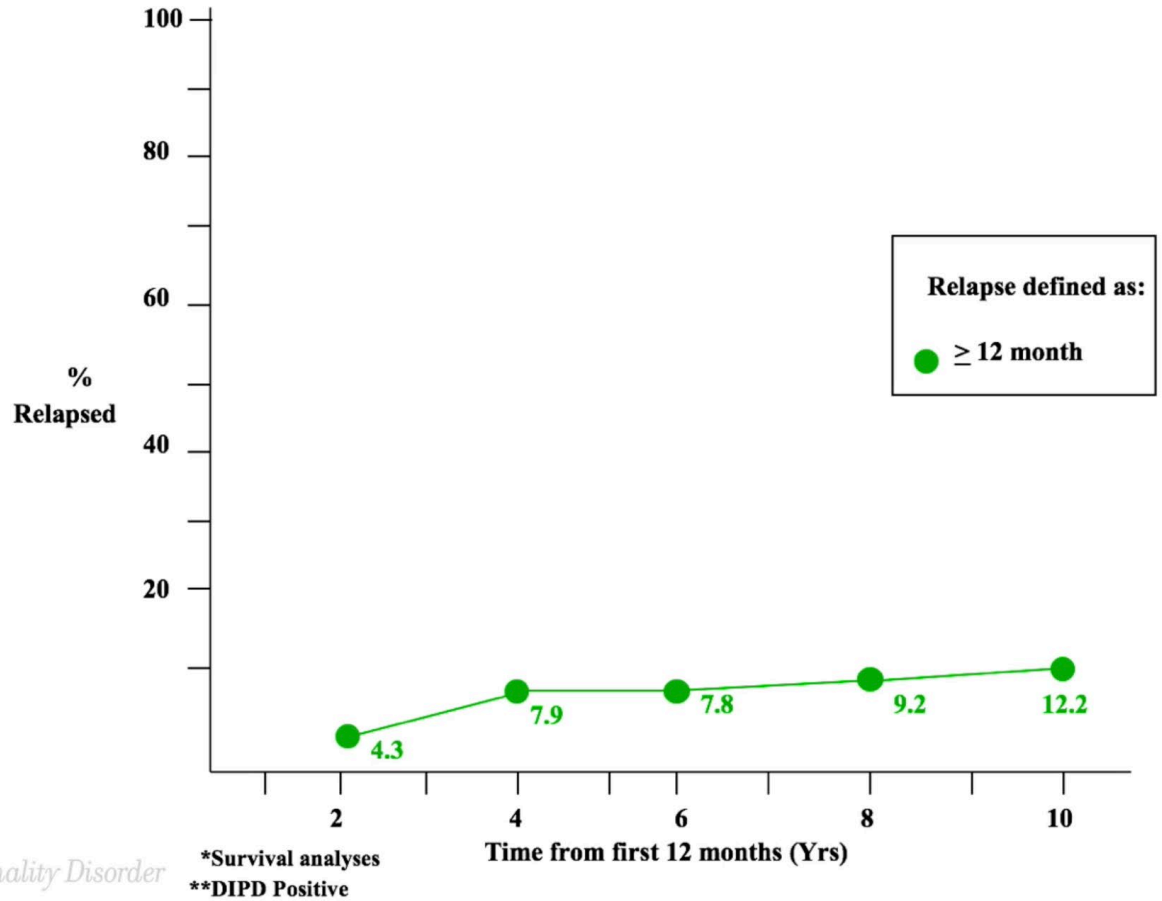
- Genetic predisposition
  - Heritability ~55%
  - Emotional sensitivity/affective instability, interpersonal hypersensitivity
  - Impulsivity and cognitive symptoms
  - Neuropeptide markers
- Environmental factors
  - *Invalidating* environment
  - Insecure attachment
  - Childhood neglect and trauma
  - Family marital or psychiatric problems

Course



NEJM 2011

TEN YEAR PROBABILITY* OF RELAPSE FOR BPD**



*Survival analyses
**DIPD Positive

Approach

- Refer for psychiatric consultation!

Psychoeducation

- Make and disclose the diagnosis!
- Explain etiologic factors
- Discuss the triggers for symptoms – sensitivity to external stressors (ie. interpersonal, environmental, financial, etc)
- Discuss expected course of illness
- There are therapies that are shown to be helpful
  - Majority improve without receiving gold standard/manualized therapies
- Review and connect with appropriate resources

General Approach in Primary Care

- Frame clinical problems with consideration of the BPD diagnosis
  - Make and disclose the diagnosis
  - Understand for yourself how interpersonal hypersensitivity and emotional dysregulation impacts caregiving relationships
  - Medicalizes and labels symptoms vs character flaws
- Validate the patient's subjective distress
  - seeing the patient's experience as legitimate and understandable (not the same as agreeing!); making sense of their intense emotions
  - Will help reduce emotional reactivity, patient feels more connected
- Tolerate anger empathically, but do not give in to demands
  - Don't condone or reinforce unacceptable behaviour
  - Maintain calm presence, outward nonreactivity, validating stance
  - Explain that such behaviours make it challenging to provide the care they are seeking

General Approach in Primary Care

- Maintain standards of good care
  - Set limits… and observe them! Be transparent
  - Frequent brief and consistent visits
  - Have patient prioritize the most urgent medical issue
  - Set goals to accomplish between appointments; patient accountability
  - Communicate proactively with other medical professionals
- Prescribe conservatively
- Respond to self-harm and suicidal behaviour with concern and assessment of risk

Therapeutic Approach

- Education is essential
  - What are the symptoms, what is driving their reactions
- Non-specific factors are central
  - Reliability, support, listening, concern
- Relational issues are central
- Situational changes are central
- Pragmatism
  - Be practical!
  - No need for specific manuals or theories; listen to patient, see what works, and change course if things aren’t working

Managing Suicidality

- Suicidality and self-harm behaviours are a reaction to a stress
  - Typically an interpersonal stressor
  - Could also be some other external stressor (ie. job loss, financial stress)
- Sharp rise in overwhelming emotion in response to the stress
- Suicidal and self-harm behaviours arise as a means of attempting to escape these feelings
- Chronic SI related to ongoing chronic symptoms of BPD

Managing Suicidality – Principles

- Express concern – don’t ignore!
- Assess risk – differentiate nonlethal thoughts from true suicide intent
  - Explore thoughts and characterize (ie. passive vs active)
  - Thoughts vs actions
- Clarify precipitants
  - Interpersonal stressors or lost supports
- Ask what the patient thinks could be helpful
  - Keeps patient accountable for managing this, reinforcing their agency
- Develop a safety plan
- Hospitalize when needed (reluctantly?)
  - In primary care presentation, refer to the ER or CRC
- Discuss with colleagues – ”Don’t worry alone”

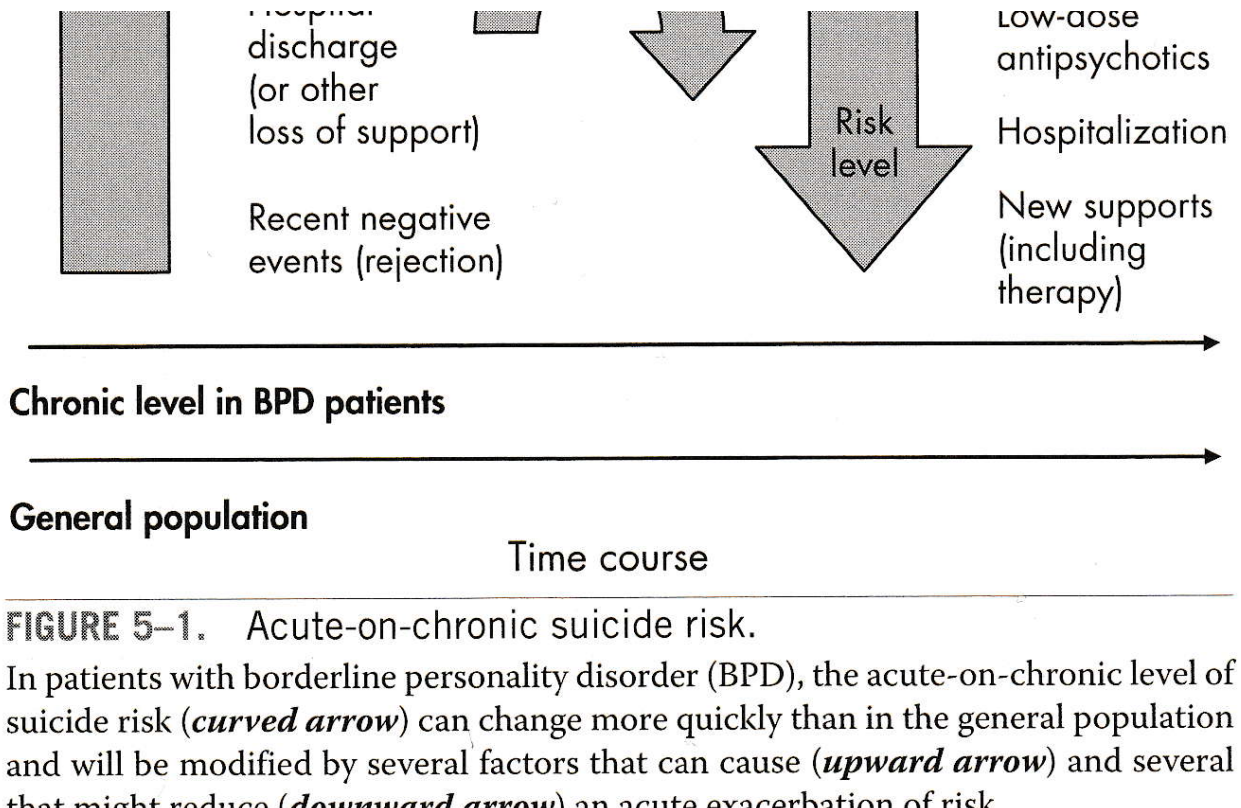


FIGURE 5–1. Acute-on-chronic suicide risk.

In patients with borderline personality disorder (BPD), the acute-on-chronic level of suicide risk (***curved arrow***) can change more quickly than in the general population and will be modified by several factors that can cause (***upward arrow***) and several that might reduce (***downward arrow***) an acute exacerbation of risk.

Source. Adapted from Gunderson JG, Links P: *Borderline Personality Disorder: A Clinical Guide,* 2nd Edition. Washington, DC, American Psychiatric Publishing, 2008. Used with permission.

diminish their own anxiety. Moreover, many health care systems lack the intensive outpatient or residential levels of care, thereby forcing clinicians to use hospitals to manage self-endangering behaviors.

Pharmacotherapy

- Therapy is the primary treatment!
- Very few RCT's
  - Data that does exist is limited and underpowered
- No medication is consistently or significantly helpful
- No medication is specifically approved
  - Anything you use for BPD symptoms is being used "off-label"
- Polypharmacy ineffective
  - Improvement is inversely proportional to how many medications are used

Pharmacotherapy Principles

- Communicate limited expectations
  - Do not want to promote externalization
  - Want to be realistic about what to expect
- Collaborative approach
  - Onus on patient to monitor/track symptoms and improvement
- Emphasize need for responsible usage
- Don’t be proactive!
  - Only prescribe in BPD if it is initiated by a patient request, or if you objectively judge a patient to be severely distressed (ie poor sleep, worsened depressive symptoms)
- Be willing but cautious
- Taper off of ineffective medications

Pharmacotherapy

- Atypical antipsychotics
  - Impulsivity/anger, mood instability, cognitive/perceptual
  - Broadest effectiveness, with significant side effect burden
  - Aripiprazole – 2 – 10mg daily (typically not more than 5 mg)
    - Weight neutral, still need to screen for metabolic side effects
    - Can be “activating” and/or interfere with sleep, take in the AM
    - Not particularly helpful as a PRN
  - Quetiapine – 25mg – 200mg daily total
    - Sedating, biggest regular dose should be @HS
    - Can be very helpful as a PRN (25-50 mg)
    - Particularly problematic for weight gain/metabolic side effects

Pharmacotherapy

- Antidepressants (SSRI's)
  - Mood and/or anxiety symptoms and comorbid disorders. Look for comorbidities!
  - Could potentially be helpful for impulsivity and mood instability symptoms
  - Modest effect, fewer side effects than antipsychotics
  - Comorbid depression is difficult to treat until BPD is treated (ie. treat BPD as the "primary" disorder)
  - Avoid TCA's or anything lethal in overdose
- Mood stabilizers – no longer recommended
- Benzodiazepines – no role!

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Questions?