Background  Borderline personality disorder (BPD) is identified by a pervasive pattern of instability of relationships, self-image, and mood, as well as marked impulsivity (1). The prevalence of BPD in the general population is 1-2%, and, despite the impression of a female predominance, evidence indicates that it occurs equally frequently in men and women (2). The stresses of serious illness may bring out these patients’ most dysfunctional coping strategies, which can be uniquely challenging for medical professionals. This Fast Fact provides strategies for successful interactions with patients and patients’ caregivers with BPD.

Diagnosing BPD:
The diagnosis of BPD requires a skilled clinical interview conducted by a knowledgeable examiner who has a longitudinal view of the affected patient. In the palliative care setting, certain behaviors and interactions with other individuals are clues to a BPD diagnosis if not previously established.
- Individuals with BPD evoke strong emotional feelings in clinicians, including both negative emotions (anger, disgust, frustration, and anxiety) and over-identification, which may lead to attempts to “rescue” the patient.
- Individuals with BPD have difficulty sustaining ambivalent feelings and may instead label clinicians as either “wonderful” or “terrible”, a defense mechanism known as “splitting”.
- Individuals with BPD will go to great lengths to avoid real or imagined abandonment. They may demand multiple provider visits per day and become angry or withdrawn when demands for extra attention or special exceptions are not met. They are more likely to threaten legal action against providers when they perceive that their needs have not been met.
- Impulsive behavior, including inappropriate use of prescribed medications, signing out against medical advice, and inconsistency in decision-making, occur commonly.
- Defects in cognitive functioning, especially decision making, conflict resolution, and “effortful control” (the ability to inhibit or activate behavior to adapt to a situation) affect the ability to make reasoned decisions about medical care and sustain meaningful interactions with loved ones and medical staff.

Strategies for working individuals with BPD (4, 5, 6, 9):
- Remember that the individual with BPD is suffering. Monitor your own feelings and refrain from responding emotionally or aggressively to verbal attacks and manipulation (See Fast Facts #59, 172 and 203).
- Begin encounters with a tactful assessment and acknowledgment of the individual's distress, and focus on specific problems. Address problem behaviors directly with statements such as “We want to continue to treat you, but if you threaten to hurt other people we will have to have you escorted out of the clinic”.
- Recognize splitting behavior (when clinicians find themselves exuberantly praised or labeled as the ‘only one who has ever been helpful’ to the patient). Clinicians should avoid excessive familiarity and should instead identify themselves as part of a unified treatment team with a common plan.
- Set explicit limits on disruptive behavior such as angry outbursts or harm to self or property. A written treatment contract which specifies consequences may be helpful. Expect the individual to test the limits and be prepared to respond consistently.

Clinician Self Care and Use of the Interdisciplinary Team
- Frequent debriefing with the interdisciplinary team and key clinicians (e.g., other consultants) where you have an opportunity to share the feelings you experience in working with a BPD patients is essential for practitioner self-care (See Fast Facts #167-170).
- Involve the treatment team in setting limits on behaviors (e.g., angry outbursts), visit frequency, and inappropriate use of medications. Carefully document all interactions with the patient or family member, including specific behaviors.
• Utilize consultants. A psychiatric consult-liaison service or the patient’s own psychiatrist or psychologist, if the patient has one, should be involved in developing a plan for successful interaction the individual. If a patient’s prognosis is long enough, consider requiring participation in psychological or psychiatric care as a condition of your continued involvement.

References

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