BORDERLINE PERSONALITY DISORDER: EVIDENCE BASED MANAGEMENT STRATEGIES

Key Take Home Messages

1. BPD is frequently seen in practice and associated with several management challenges including patient self-harm behavior and maintaining a therapeutic patient-physician relationship.
2. Although BPD is a chronic mental health condition, most patients with BPD improve over time including a substantial number that experience a remission of the disorder.
3. Evidence to support pharmacology for the treatment of borderline personality disorder is limited with no single medication approved for the treatment of borderline personality disorder.
4. Good evidence supports structured therapies which emphasize development of a therapeutic alliance between physician and patient along with regular scheduled office visits with continuity of care.

Diagnosis

1. Emotional dysregulation: heightened emotional sensitivity, inability to regulate intense emotional responses and slow return to emotional baseline. Patients exhibit range of intense moods and they often move from one mood to another rapidly and unpredictably.
2. Instability in sense of self: chronic sense of emptiness including feelingng like there is nothing inside or feeling dead. Patients have low esteem and sense of worthlessness.
3. Behavioural instability: includes impulsivity in multiple areas such as alcohol or drugs, unsafe sex, shop lifting, eating binges, gambling and fast driving.
4. Recurrent self harm behaviors including self-mutilation and suicide.
5. Cognitive instability: transient stress related paranoid ideation or severe dissociative symptoms.
6. Interpersonal instability: profound sense of abandonment which tends to manifest in desperate efforts to avoid being left alone: calling people on the phone repeatedly or refusing to leave the office. Alternating between intensely idealizing and devaluing close relationships.

Management

1. Since patients have problems with under regulation of emotions: goal is to teach emotional regulation skills. Helping patients articulate their emotional experience is key.
2. Primary focus is providing validation and negotiate treatment plans whenever possible.
3. It is useful to conceptualize self-injury as an expected but unhealthy behavior one encounters when treating patients with BPD. Since a primary function of self-injury is to reduce dysphoria, interventions need to identify causes of the dysphoria and help the patient develop more effective coping mechanisms.
4. Aim of dialectal behavioural therapy is to help patients develop new ways of thinking, feeling, and coping. Rather than focusing on the past, one looks at the present situation with a goal to replace maladaptive methods of coping with more effective ways of achieving specific changes.
5. Evidence supporting effectiveness of commonly prescribed drugs for individuals with BPD is limited. Often the role of a family physician maybe to reduce the number of psychiatric medications being prescribed.
6. Karpman Drama Triangle provides useful framework for understanding complex and often conflictual relationship between care giver and individual with a borderline personality disorder.

References

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