Curbside Consultation

Treating Patients with Borderline Personality Disorder in the Medical Office

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Case scenarios are written to express typical situations that family physicians may encounter; authors remain anonymous. Please send scenarios to Caroline Wellbery, MD, at afpjournal@aafp.org. Materials are edited to retain confidentiality.

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Case Scenario

One of my patients is a 58-year-old woman with borderline personality disorder, uncontrolled type 2 diabetes mellitus, and end-stage renal disease requiring hemodialysis three times per week. I saw her recently for a follow-up visit after hospitalization—her third in six weeks. Each time she was admitted with similar symptoms: abdominal pain, nausea, vomiting, hypotension, and hyperglycemia after missing a regularly scheduled dialysis appointment. Each hospitalization had been preceded by a missed appointment.

During her most recent hospitalization, she underwent a psychiatric evaluation that suggested she lacked insight into her medical condition and did not seem to understand her need for care or have the ability to participate in it. The results of the evaluation narrowly declared her competent enough to make her own medical decisions. She adamantly refused to go to an extended care facility where her diabetes and renal failure could be more reliably treated. She lives at home with her adult daughter and son.

She is noncompliant about taking her diabetes medications. Her last A1C reading was 11.2%. When her blood glucose is markedly elevated, she feels ill and skips dialysis. When she arrived for her visit today, she became argumentative with my front desk staff. She was 20 minutes late and was asked to reschedule her appointment per office policy. She was a no-show for her previous two office visits. I am not sure what to do next.

Commentary

The prevalence of borderline personality disorder in the general population is thought to be between 1% and 2%.[1,2] As family physicians, we often treat these patients for chronic medical conditions. There are multiple obstacles to caring for these patients because of their difficult behaviors (e.g., angry outbursts, self-harm, suicidal ideation) and lack of social skills. They tend to see people and situations as all good or all bad.[3] They are manipulative and will pit one side against the other when dealing with an organization or family unit to keep both sides off balance. By creating conflict or a diversion, these patients are more likely to achieve their goal, such as not being abandoned or receiving more attention from their physician.

Lack of support systems represents another obstacle to care. The lives of patients with borderline personality disorder are often chaotic because of their unstable interpersonal relationships, impulsivity, identity disturbance, and mood reactivity.[3] Family members or friends may not be willing or able to assist in their care.

Patients whose borderline personality disorder is controlled through efficacious treatment strategies are more likely to successfully manage their other medical conditions.[4] It was previously thought that the disorder could not be treated, but in recent years several different types of psychotherapies have been developed and studied.[5] The best studied of these approaches is dialectical behavior therapy. Dialectical behavior therapy blends cognitive behavior therapy with Eastern mindfulness strategies to encourage the "synthesis of opposites."[6] This involves a conciliatory approach to the tendency of patients with borderline personality disorder to categorize their experiences in stark and often dichotomous terms. Asking patients whether their behaviors are

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constructive or destructive, and whether their behaviors help them achieve their goals or serve as impediments to those goals, helps to keep these ideas present in their minds. Small studies have shown that dialectical behavior therapy is effective in reducing inappropriate anger, decreasing self-harm, and improving overall global psychological functioning.[5] Although the findings suggest that psychotherapy may play an important role in managing this hard-to-treat condition, further studies are needed to confirm this benefit.

If patients will not agree to behavior therapy, pharmacotherapy can be useful in managing specific behaviors or comorbid psychiatric conditions. For instance, if a patient has agitation or hallucinations, a second-generation antipsychotic (e.g. ziprasidone [Geodon], aripiprazole [Abilify]) might be appropriate. If a patient has bipolar disorder or major depression, these disorders should be treated concurrently. There is preliminary evidence that second-generation antipsychotics, mood stabilizers, and omega-3 fatty acids may have beneficial effects,[7,8] but the evidence for this is not robust. First-generation antipsychotics or antidepressants are not currently recommended because there is not enough evidence to support their use for treating borderline personality disorder.[7]

In the case of this patient, the office staff should show her to an examination room despite her late arrival. Next, a treatment plan in which she can take more personal ownership of her health should be negotiated. If she is encouraged (and allowed) to take more control over the plan, she will likely be more amenable to following through with it. Together, the physician and patient should draft a contract for compliance. She should be referred to a psychotherapist who is adept at dialectical behavior therapy. To provide assistance with her diabetes, family members should be enlisted to help with insulin administration to the extent that they are able. Although patients may not initially be receptive to therapy, they may become more receptive in the future. Physicians should thus remain vigilant in this regard.

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