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Patients with Borderline Personality Disorders Challenge HCH Clinicians

Patients with borderline personality disorder (BPD) have been described as having a "black hole of need." They can be friendly one minute, and "turn on you like a snake" the next. Therapists working with individuals who have BPD are advised to be prepared to "look into the heart of darkness."[1] Indeed, patients who have this disorder have described themselves as "living in the dead zone."[2] Yet the same individuals also are described as "intelligent, articulate survivors who are motivated to get better."

Personality disorders are among the least recognized and understood disorders in both psychiatry and general medicine, despite the fact that they are commonly seen by mental health professionals.[3]

> **Personality Disorders:** "…long-term, maladaptive patterns of perception, emotional regulation, anxiety, and impulse control" that can result in "enormous personal and societal costs, including lost productivity, hospitalizations, significant unhappiness, imprisonment, and suicide."[3]

The Diagnostic and Statistical Manual of Mental Disorders (DSM IV) organizes personality disorders into three clusters, each with distinctive behavioral features. Examples of disorders in each cluster include the following:

- **Cluster A** – schizoid, paranoid, and schizotypal personality disorders, characterized by odd or eccentric behavior;
- **Cluster B** – antisocial, narcissistic, and borderline personality disorders, marked by dramatic, emotional, and erratic behavior;
- **Cluster C** – avoidant, dependent, and compulsive personality disorders, manifest as anxious and fearful behavior.

Although each cluster has a dominant feature, people with personality disorders often exhibit traits from all three clusters.[1]

COMPLEX CONDITIONS The defining characteristic of BPD is instability in four domains of life—relationships, mood, self-image, and impulse control, according to **Rudra Prakash, MD,** professor of clinical psychiatry at Vanderbilt University and consulting psychiatrist for the Downtown Clinic HCH project in Nashville, Tennessee. This instability manifests itself in a number of ways, Dr. Prakash notes, including:

- Multiple, unhealthy relationships;
- Impulsive behavior, such as promiscuity and drug abuse;
- A tendency to view oneself as a victim; and
- Sensitivity to rejection/fear of abandonment, leading to the desire to do anything to please.

In addition, he notes, people with BPD complain of chronic boredom and a sense of emptiness. They are at risk for suicide attempts and for parasuicidal behaviors—intentional, nonfatal self-injury such as cutting and burning, notes **Lisa Cunningham Roberts, MA, LMHC,** Lead Mental Health Practitioner for the HCH project at Seattle's Harborview Medical Center.

BPD affects 2 percent of all adults, mostly young women, making it more common than schizophrenia or bipolar disorder (manic-depressive illness).[4] Once thought to be at the "borderline" of psychosis, people with BPD account for 10 percent of individuals seen in mental health outpatient clinics and 20 percent of psychiatric inpatients.[5]

The complexity of their medical picture complicates treatment for patients with BPD, who may have a variety of co-occurring psychiatric conditions, including mood, anxiety, and psychotic disorders; eating disorders; and other personality disorders. A combination of early neglect and lack of self-care leaves individuals with BPD at risk for a host of medical problems, as well (see related story).

As many as 21 percent of people with substance abuse disorders are estimated to have BPD, and 40 percent or more of people who are homeless report having a substance abuse disorder during the past year.[1,6] Substance abuse fits the pattern of BPD because it is impulsive, self-injurious, and it sabotages treatment, notes **Jeff Yungman, MSW, MPH,** Mental Health Team Leader for Crisis Ministries in Charleston, South Carolina, which receives HCH and PATH (Projects for Assistance in Transition from Homelessness) funding.

> "People with BPD become the pet project of an individual or agency. The hook they use is, 'You're the only one who can help me.' But you burn out because you can't do what they want, either because it won't work, it isn't needed, or it's unethical. The patient gets mad and moves on."
>
> *– Pam Schlegel, MSW*
> *Partnership Health Center, Missoula, Montana*

Individuals with BPD are vulnerable to homelessness for all of the reasons that others with mental illnesses are at risk, including job loss, lack of family support, and substance abuse. But their tendency to have volatile relationships with everyone around them—including spouses, bosses, coworkers, landlords, and clinicians—and their inability to trust others make it especially difficult for them to maintain economic and residential stability.

THE ROLE OF TRAUMA Though the cause of BPD is unknown, most researchers and clinicians point to a combination of nature and nurture, and an especially strong correlation with early childhood abuse and neglect. Studies show that many, but not all, individuals with BPD report a history of abuse, neglect, or separation as young children.[4] Forty to 71 percent of BPD patients report having been sexually abused, usually by a non-caregiver.[4] According to a 1998 study, 60 percent of homeless women had been abused by the age of 12, and over 90% reported physical or sexual abuse during their lifetime.[7]

People with BPD live in a "sea of intense emotions," notes **Marty Hoiness, MD,** former Medical Director of the Dialectical Behavior Therapy (DBT) program at Harborview Medical Center. DBT, considered by many to be the gold standard of treatment for people with BPD, was developed by Marsha M. Linehan, PhD, who believes that individuals with BPD are born with reactive, sensitive emotions, and their environment doesn't teach them how to regulate those emotions.

Seen in this light, such behaviors as cutting, drug use, and reckless sex are attempts to regulate painful emotions, says Dr. Hoiness. These behaviors help to numb the pain temporarily, but also lead to more problems, including homelessness. Dr. Hoiness has been a research therapist for Dr. Linehan's studies of the effectiveness of DBT for patients with BPD, and he is currently an attending psychiatrist at Virginia Mason Medical Center in Seattle and clinical instructor at the University of Washington Medical School.

The relationship between biological predisposition and environmental stressors is explored in detail by Patricia Hoffman Judd, PhD, and Thomas H. McGlashan, MD, in their book *A Developmental Model of Borderline Personality Disorder*.[1] The authors believe that individuals with BPD are in greater need of adequate parenting because of their greater biological vulnerability. Instead, these individuals may be born into homes marked by parental unavailability or neglect, active withdrawal, or inconsistent support.

DIFFICULT, DEMANDING PATIENTS The child with a genetic predisposition to hypersensitivity who doesn't get his or her needs met learns to cry louder and be more demanding, notes **Helen Oetjen, PhD,** Interim Program Director of COTS (Committee on Temporary Shelter) in Burlington, VT. COTS is part of a 5-agency collaborative in Burlington that receives HCH funding. The problem, Oetjen notes, is that these same behaviors in adults are off-putting. "Patients with BPD inadvertantly push people away while trying to bring them closer," she says.

Within a homeless services or health care agency, one individual may try to engage many service providers—from clinicians to support staff—to get the same thing. Staff may find they are providing the same or even contradictory services to one individual. People with BPD tie up an agency's resources, try the patience of the staff, and end up sabotaging their own treatment.

Patients with BPD are unable to think dichotomously—everything is either all good or all bad. Therefore they often engage in what psychiatrists call "splitting," a habit of "alternately vilifying and praising, blaming and exonerating, disparaging and extolling others and even themselves."[8] Working with them becomes an "exhausting tug of war," Cunningham Roberts notes.

However, Cunningham Roberts cautions that the clinician's inability to work effectively with a patient who has BPD may lead the clinician to blame the victim. "It's easier to blame the patient than to recognize our own counterproductive strategies," she says. In fact, she believes the diagnosis of BPD may be used inappropriately as a catch-all term for the patient who is needy, intense, or demanding. A newly sober patient may present with many of the same characteristics.

PREVENTING STAFF BURNOUT HCH clinicians and BPD experts agree that it's easy to feel inept and frustrated when working with a patient who has BPD. They stress the need for close supervision and support and for working as part of a team. Just as an individual with BPD will engage and tax a whole community to get his or her needs met, so, too, must the response be a community or team effort.[1]

Team work can be as therapeutic for the clinician as it is for the patient. Team members support one another and share their successes and their frustrations. It's important for all members of the team to be in agreement about a patient's treatment, notes **Michael Misgen, LPC,** PATH Team Program Manager for the Colorado Coalition for the Homeless. Because the BPD patient will try to engage as many staff as possible, "staff members start taking sides if they're not careful," he says.

HCH clinicians may have an edge over others working with BPD patients because many of the qualities considered important for individual therapists — empathy, flexibility, creativity, patience, the capacity for introspection, willingness to seek consultation, a strong collegial support system, and a sense of humor[1] —are also critical in working with homeless people.

Oetjen encourages her fellow clinicians to take advantage of whatever training may be available, whether an in-service by psychiatrists, presentations by therapy students, or programs in the local community. In the end, working with patients who have BPD involves maintaining perspective, Judd and McGlashan believe. "Humility in the face of the tragic and heroic efforts of the patient to survive and maintain human connection provides [such] perspective," they conclude. ■

CASE STUDY

Z is a 27-year-old Caucasian female with a diagnosis of borderline personality disorder. She was referred to a DBT program because she was the highest user of emergency services in the county. She spent at least half of the year prior to entering treatment either in psychiatric hospitals or in jail (generally for assaulting health care workers or for drug or prostitution charges). She attempted suicide weekly and cut on herself daily. She had a history of severe childhood abuse and was abused by her first husband. She also had severe depression, obsessive compulsive disorder, and post-traumatic stress disorder. Z entered treatment in transitional housing but quickly became homeless after she attempted to jump off her building. She began the program angry, out of control, and suicidal, but desperate for help. She engaged in individual therapy and group skills training and worked with a case aide to negotiate the public housing system. She frequently returned to drugs or prostitution and ended up in jail or in the hospital. Her therapists continued to work with her despite this behavior. Gradually, Z began solving her problems rather than avoiding them. She started drug treatment and entered transitional housing, then permanent housing. She also got a part-time job. At the end of the 2-year DBT program, she hadn't been in the hospital, injured herself, or attempted suicide for one year.

–Marty Holness, MD, Seattle, Washington

DBT Teaches Acceptance and Change

People with borderline personality disorder see things in black and white. Dialectical Behavior Therapy (DBT) helps them see things in plaid, says Dr. Marty Hoiness.

DBT is the brainchild of Marsha M. Linehan, PhD, Professor of Psychology and Director of the Behavioral Research and Therapy Clinics at the University of Washington in Seattle. It is a blend of behavior therapy, dialectical philosophy, and Zen Buddhist practices, originally developed to treat chronically suicidal individuals.[9]

As the name implies, the overarching characteristic of DBT is an emphasis on "dialectics"—that is, the reconciliation of opposites in a continual process of synthesis.[10] The most fundamental dialectic is the necessity of accepting patients as they are while trying to teach them to change. "Change won't come without acceptance, because patients with BPD have always felt invalidated," Dr. Hoiness explains.

Key components of outpatient DBT include a highly structured skills group, individual psychotherapy focused on using skills to solve problems, and telephone consultation with therapists, allowing for skills coaching in a natural environment. A therapist consultation team provides support and a therapeutic environment for the staff.

In the skills group, DBT patients learn distress tolerance, crisis management, and interpersonal skills. Individual therapy is designed to address a hierarchy of behaviors, from life-threatening behaviors to those that interfere with therapy or quality-of-life. Most BPD patients want to focus on quality-of-life behaviors, including problems related to homelessness, Dr. Hoiness says. But they must first resolve behaviors that threaten their life or interfere with their ability to benefit from therapy.

"We hold them responsible for their outrageous behaviors," Dr. Hoiness says. "They may have learned that anger is effective, but we teach them to do things differently."

DBT is an intensive, 2-year program that includes an activity and a work/school requirement. The program at Harborview Medical Center formerly directed by Dr. Hoiness has 50 patients at any one time; two-thirds of them are women and one-third are homeless. Working with homeless people is especially challenging, Dr. Hoiness says. If homelessness

interferes with a client's ability to continue therapy, obtaining stable housing becomes the focus of therapy. DBT therapists don't do things for their clients, however—they teach clients how to take care of themselves.

How do homeless patients deal with the intensity and length of DBT therapy? "Most patients hate therapy, but they hate their life more," says Lisa Cunningham Roberts. "It's hard to get in, so they find a way to stick with it." The Harborview DBT program has a 77 percent completion rate. Of 43 people for whom they have data, 10 dropped out, only one of whom was homeless.

DBT in a private setting costs from $150 to $200 an hour, Dr. Hoiness says. Medicaid and Medicare will cover the costs, but private insurance won't pay. The waiting lists are long, in part because DBT works.

Studies have found that DBT reduces parasuicidal behaviors, inpatient hospital days, and drug abuse, and improves social functioning.[1,10] DBT can be applied in a variety of settings, including Assertive Community Treatment (ACT) teams. A study of mental health ACT teams in Kalamazoo, Michigan, that used DBT found that ACT team clients with BPD had more work days, fewer hospital days, and used lower intensity services on discharge.[5] ■

Treatment Strategies Focus on Setting Limits

If you're a parent or you know one, working with a homeless individual who has a borderline personality disorder will seem familiar. Successful interventions fall somewhere between setting limits with a 2-year-old and practicing tough love with a teenager. Based on their experiences working with patients who have BPD, HCH clinicians offer the following strategies they find effective.

SET LIMITS Helen Oetjen talks about the importance of what she calls "contingency management," which involves spelling out, "if x behavior happens, then y consequence will occur." The behaviors and consequences can be either positive or negative. For example, Oetjen says, you may tell the patient, "If you show up at the shelter 3 hours late and scream when you're not admitted, you will lose your bed for the following night also." On the positive side, you might say, "If you apply for three jobs today, you can stay out later tonight."

This type of effort demands that all staff be aware of the treatment strategy and be prepared to follow through with it, Michael Misgen notes. For example, if a patient with BPD who ties up the phone lines signs a behavioral contract that permits her to call her case manager only once a day, the person who answers the phone has to be told that it's all right to hang up if she calls multiple times. Likewise, security must be informed if a patient who shows up for a visit when he is not supposed to be there causes problems when asked to leave.

ENSURE PHYSICAL SAFETY Work first on trying to reduce behaviors that put a patient's physical safety at risk, including self-mutilation, drug addiction, anorexia, and risky sexual involvement, notes **Jennifer Moore, MSW,** a case manager at Crisis Ministries in Charleston, South Carolina.

TREAT SUBSTANCE ABUSE Untreated substance abuse is the single most important obstacle to treatment for BPD, according to Dr. Rudra Prakash. People with severe chemical dependencies and BPD are probably best treated in an integrated program that offers treatment for both disorders in the same setting.[1]

VALIDATE EMOTIONS Don't validate the invalid, but find something true in the way a patient relates information, Oetjen says. Empathy and validation help counteract the rejection these patients have come to expect. It is possible to both validate emotions and correct assumptions, notes Lisa Cunningham Roberts. For example, it's appropriate to say, "You didn't deserve this AND you have to learn to cope," she says.

REINFORCE POSITIVE COPING SKILLS People with BPD are often in crisis, and the tendency is to pay more attention to them, for example, after they've cut themselves; but this only reinforces self-destructive habits, HCH clinicians note. They recommend giving patients more attention for positive coping skills, such as learning ways to self-soothe. "This is counterintuitive, and it's hard to do," Oetjen acknowledges.

PREPARE FOR HOUSING Though there is nothing inherent in the diagnosis of BPD that makes an individual a poor risk for housing, patients who are housed before they have learned some coping skills can "agitate a whole building and get evicted," Misgen observes. Like other individuals with mental illnesses, people with BPD often have poor landlord references and may be unable to work. Because subsidized housing is in short supply in many communities, there aren't many second chances for these clients.

REFER FOR LONG-TERM THERAPY It is difficult to engage clients in a homeless shelter in the type of long-term therapy that BPD requires, notes Jeff Yungman. Furthermore, it may be inappropriate to offer therapy unless you are trained to do so, Oetjen says. "Individuals with BPD don't have clear boundaries, and they will want to tell you everything that's happened to them. But if they relive their trauma before they have learned appropriate coping skills, this may escalate self-harming behaviors," Oetjen believes.

ROLE OF MEDICATION There is no medication to treat BPD, but most clinicians agree that medications can reduce symptoms of comorbid psychiatric conditions, including mood and anxiety disor-

ders, ameliorate suffering, and allow patients to make better use of psychotherapeutic interventions.[1]

The American Psychiatric Association (APA) Work Group on Borderline Personality recommends the use of medication for three kinds of symptoms in patients with BPD: unstable moods, impulsive behavior, and distorted thinking or perception.[8] Appropriate medications include antidepressants, mood stabilizers, and antipsychotic drugs. Although anti-anxiety drugs also relieve symptoms, they may place patients at risk for substance misuse and addiction, notes the APA Work Group.

REIMBURSEMENT ISSUES For many patients with BPD, reimbursement problems make treatment difficult or impossible. Most private insurance will not cover treatment for BPD, which is considered an Axis II disorder according to the DSM IV. Even public mental health systems are limiting the psychiatric conditions they cover as a way to control costs.

In some States, only individuals deemed to have "severe and persistent mental illness" (SPMI) can qualify for services—a criterion that people with BPD may not meet. Moreover, many individuals with BPD may not qualify for Supplemental Security Income (SSI) or Medicaid services (which are linked to SSI in most States) because of inadequate documentation of their functional impairments or because they exceed the level of resources required for eligibility.

Though a number of individuals with BPD do qualify for some type of insurance coverage based on a comorbid Axis I disorder (such as depression or bipolar disorder), Dr. Prakash believes that this can be misleading, both to patients and their caregivers. "If you gloss over the diagnosis of BPD because you fear lack of reimbursement, this is a gross injustice to the patient," he says. "The patient deserves information about and appropriate care for each of the problems that he or she has."

POSITIVE PROGNOSIS For all of the difficulties the disease presents, patients with BPD do get better, Dr. Marty Hoiness says. Sometimes their successes are small—they may learn to limit their calls and visits to their case manager or primary care physician, or they may be able to go days or even weeks between periods of destructive behavior. In other cases, individuals with BPD who have been homeless are able to return to work and reconnect with their families.

Ultimately, people with BPD are nothing if not survivors. "They deserve to be dealt with respectfully and firmly, with clear limits and genuine esteem," advises Misgen. "We should lavishly praise their successes." ■

Meeting the Challenge of BPD in Primary Care

Patients with borderline personality disorder present significant challenges to primary care providers in Health Care for the Homeless facilities. They may have a host of health problems related to early maltreatment and poor self-care, including substance abuse, self-mutilation, suicide attempts, promiscuity, and eating disorders.[1]

In addition, patients with BPD are susceptible to chronic pain syndromes, such as fibromyalgia and chronic fatigue syndrome (CFS), and they may not adhere to recommended treatment for chronic conditions such as heart disease and diabetes. Half of the BPD patients in primary care settings report not receiving mental health treatment in the past year.[11]

But perhaps the biggest problem that BPD patients present to the primary care physician is their inability to communicate clearly what is bothering them. BPD patients may "substitute the language of physical pain to describe both their physical and emotional suffering," Patricia Hoffman Judd, PhD, and Thomas H. McGlashan, MD, write.[1]

As a medical social worker, Pam Schlegel is quite familiar with this phenomenon. "BPD patients come in with emergencies that aren't emergencies, and pain we can't figure out," Schlegel says. Still, because patients with BPD may have physical problems, the primary care staff must run the necessary tests to eliminate potential medical disorders. "We end up with extremely costly patients who have no diagnoses," Schlegel says.

If patients with BPD have trouble communicating their problems, they have less trouble conveying their preferred solutions. "They self-diagnose, and they'll tell you what medications to give them," says **Jerri Robinson, RN, BSN,** triage nurse for the Family Health Center in Kalamazoo, Michigan. Many no longer have insurance coverage for prescriptions they've received previously, but they want the same medications. Others have not taken medications prescribed in the past and will come in with a "bag of drugs," Robinson says.

BPD patients desperately want relief, but their inability to form a trusting relationship with primary care staff interferes with the provision of adequate care. The HCH clinician's role is to "facilitate appropriate use of a health care visit," Schlegel says. This may involve appointing a single provider as the contact person for the patient and scheduling regular appointments. "If you validate their concerns and set aside time for them, this reduces their anxiety and eliminates the shotgun approach that sabotages getting their needs met," she notes. ■

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