

The Borderline Patient: Mental Health Clinicians' Experience and Views

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اضطراب الشخصية الحدية

وجهة نظر وخبرة الممارسين الإكلينيكين في مجال الصحة النفسية

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Abstract:

Traditionally training and service planning in mental health were focused on Psychosis, Affective and Neurotic disorders. Recently Personality disorders represent a significant portion of clinicians' caseload and Mental Health services need to meet their needs.

Aim:

1. To examine the adult mental health clinicians' experience while working with individuals diagnosed with Borderline Personality disorder (BPD) and ways of supporting them.
2. To identify training needs

Method:

A cross sectional survey of adult mental health clinicians employed by Northamptonshire Healthcare NHS Foundation Trust (NHFT)

Results:

1. Response rate: 69% (185 of 269) including: psychiatrists 40 (85%), community staff 98 and inpatient staff 47.
2. Self-rated ability to diagnose/identify BPD: very good: 19 (10%). Good, 65 (35%), average: 74 (40%) and 19 (10%) were unsure and 9 (5%) did not answer. Preferred diagnostic system: ICD-10: 27 (15%), DSM-IV: 9 (5%), clinical sense: 139 (75%) and 9 (5%) did not answer.
3. Working with BPD is experienced as: Enjoyable: 9 (5%), challenging: 111 (60%), stressful: 27 (15%), very stressful: 19 (10%), I hardly like: 9 (5%), no answer: 9 (5%). 159 (85%) agreed that training is needed, 19 (10%) did not agree, 6 (3%) were unsure and 4 (2%) did not answer.

Conclusion: The majority of clinicians' experience managing individuals diagnosed with BPD as challenging and agreed that training is needed.

Background:

Personality disorder symptoms are alloplastic i.e. alter and adapt to the external environment and are ego

syntonic i.e. acceptable to the ego¹. Clinicians may not have difficulty making diagnosis but usually find the

clinical management challenging. The majority of patients diagnosed with BPD have experienced sexual, physical and or emotional abuse in their childhood² Kernberg (1977,1981) differentiated neurotic, psychotic and borderline “intrapsychic organisations” which are to some extent independent of manifest symptomatology³.

Patients diagnosed with BPD stand on the border between psychosis and neurosis. They are characterised by unstable affect, emotions, behaviour, object relations and self-image with intense affective instability and impulsivity together with an unstable sense of self-identity. It is often manifested by impulsive, self-directed aggression, suicide attempts, substance abuse, chronic feelings of emptiness and persistent pattern of severely unstable interpersonal relationship and fear of abandonment⁴. The disorder has been called ambulatory schizophrenia, as-if personality (a term coined by Helene Deutsch), pseudo-neurotic schizophrenia (described by Paul Hoch and Philip Politan) and psychotic character disorder (described by John Frosch)¹.

Recent epidemiological surveys show that personality disorders are frequent and have been found in different countries and sociocultural settings. Personality disorder can seriously impair life of the affected individuals and can be highly disruptive to families, societies and to healthcare system. Personality status

is often a major predictive variable in determining the outcome of Axis I mental disorders and the response to treatment^{4,5}. It is therefore important that mental health clinicians feel adequately supported and trained to handle individuals diagnosed with the commonly encountered personality disorders e.g. borderline personality disorder.

The number of people suffering from BPD ranges from 1.5–5% in the general population with wide differences between studies due to lack of reliable measures¹². In the outpatient clinic BPD increases ranging from 10–15%. It is more common in women and usually diagnosis is made between the age of 18–35 years². In psychiatric inpatients the ratio increases to reach about 19 - 20%^{4,5}. However with the increased awareness of BPD presenting among the mentally ill population, there seems to be some difficulty addressing their presentations and needs of such population either due to lack of training, clinical skills or attitude problem. Treating individuals with personality disorder particularly BPD is rather complex and challenging. Clinicians who have been trained to deal with the individuals suffering from psychosis or mood disorder may not feel in a position to manage cases with BPD.

This study aims to examine clinicians’ experience with diagnosis and management of individuals diagnosed

with BPD and identify possible training gaps

Aim:

1. To study the clinical experience of mental health clinicians while working with individuals diagnosed with Borderline Personality disorder (BPD).
2. To identify training needs.

Methodology:

A cross sectional survey using a colour-coded, confidential questionnaire sent to all clinicians, from various disciplines, in Adult Mental Health service by the Clinical Governance Support Team (CGST) with a covering letter explaining the aim of the study and requested a response within 3 weeks.

Study sample:

All 269 mental health personnel were involved in the study. They include:

1. Psychiatrists: 47 (18 consultants, 14 staff Grade and ass. Specialist doctor (SAS), 15 Senior house officer (SHO).
2. Non-medical mental health professionals working in General Adult Psychiatry service including:
3. **A.** Community Mental Health Teams including 150: Community Mental Health Nurses 95, Mental Health Social Workers (SW) 35, Occupational Therapists (OT) 15 and Psychologists 5.

B. Inpatient unit 72: Psychiatric nurses 60, OT 8 and Psychologists 4.

Results:

4. Response rate: 269 questionnaires were distributed only 185 responded with an overall response of 69% including: psychiatrists 40 (85%) (15 consultants, 12 SAS and 13 SHO), community mental health professionals 98 (65%) including: community psychiatric nurses 60, (SW) 25, (OT) 10 and psychologists 3.
Inpatient staff 47 (65%) including: psychiatric nurses 40, OT 4 and 3 psychologists.
5. Self - rated ability to diagnose/ identify BPD: very good: 19 (10%). Good, 65 (35%), average: 74 (40%) and 19 (10%) were unsure and 9 (5%) did not answer. Psychiatrists (30%) very good and (70%) good in making diagnosis of BPD, Nurses 45 (45%) very good, 30 (30%) good and 25 (25%) average. OT: 4 (25%) good and 10 (75%) average and SW: 8 (30%) very good, 10 (40%) good 6 (25%) average and 1 (5%) did not answer). Psychologists: 5 (85%) very good & 1 (15%) good.
6. Preferred diagnostic system: ICD-10: 27 (15%), DSM-IV: 9 (5%), clinical sense: 139 (75%) and 9 (5%) did not answer.
7. Ability to manage BPD: very good:

- 27 (15%), good: 47 (25%), average: 83 (45%), poor: 19 (10%) and 9 (5%) did not answer.
8. Working with BPD is experienced as: Enjoyable: 9 (5%), challenging: 111 (60%), stressful: 27 (15%), very stressful: 19 (10%), I hardly like: 9 (5%), no answer: 9 (5%).
 9. Whether training is needed or not? Yes: 159 (85%), no: 19 (10%), 6 (3%) unsure and 4 (2%) did not answer.
 10. 120 (65%) believed that individuals diagnosed with BPD are mentally ill, 55 (30%) believed that they are not mentally ill, 10 (5%) did not answer. Majority of those who believed that individuals diagnosed with BPD are not mentally ill were from inpatient staff (25% from inpatient and 5% from community staff).
 11. 102 (55%) believed that BPD needs treatment by a specialist personality disorder service, 46 (25%) feel they can work with BPD but with more support and 27 (15%) undecided and 10 (5%) did not answer. 75% of Psychiatrists believed that patients with BPD are mentally ill while only 40% of non-psychiatrists believe that patients with BPD are mentally ill

Discussion:

Personality disorder is a recognised diagnostic entity in the well-known diagnostic classifications of mental disorders such as ICD-10 and DSM-

IV. Individuals diagnosed with BPD represent a significant percentage of mental health professionals' workload. The experience of clinicians with those individuals may vary according to clinicians' background, knowledge and training. James et al (2007) conducted a survey. 80% of responders view clients with BPD as more difficult to care for than other clients and 81% believed that the care offered was inadequate⁶.

The majority of the responders of our study believed that individuals diagnosed with BPD are mentally ill, however about one third of the responders did not believe that individuals diagnosed with BPD are mentally ill. An important factor that may influence clinicians' ability to work with individuals diagnosed with BPD is their attitude. In previous studies staff expressed views that may reflect a similar view or attitude including: not sick, manipulative, non-compliant⁷; time wasters, difficult to treat, not mentally ill and attention seeker⁸. This may reflect the degree of frustration and sense of helplessness. This probably indicates the need to address this in the teaching and training of the clinicians, which is likely to improve their attitude, their ability to care for BPD and promote the development of a therapeutic relationship.

Community Mental Health Team (CMHT) nurses who volunteered to participate in an awareness workshop

reported higher levels of enjoyment, security, acceptance and purpose when working with individuals diagnosed as personality disorder compared with those who did not volunteer⁹. In our study results as the majority of responders stated that training is needed.

Psychiatrists tend to use diagnostic criteria of one of the recognised classifications (ICD-10 is more preferred). Psychiatric nurses, social workers, occupational therapists and probably psychologists tend to use their clinical sense in diagnosing BPD. However this did not seem to affect the ability of clinicians to confidently identify BPD. The main difficulty clinicians raised was not about recognition of BPD but how to help and care for them?

Majority of clinicians rated working with BPD as challenging and stressful, smaller percentage described it as enjoyable and a similar percentage as: they hardly like. It is quite possible to find working with BPD challenging and demanding but enjoyable. It is also possible that the sense of frustration and lack of training render clinicians unable to experience working with BPD as enjoyable. The attitude of nurses to BPD was assessed in a study by Gallop et al (1989) who found that respondents were more likely to demonstrate affective involvement in response to the schizophrenia patients' statements and were more likely to offer belittling or

contradicting responses to the statements of patients with BPD¹⁰. Deans & Meocevic (2006) found out that psychiatric nurses experience negative emotional reactions and attitude towards people with BPD.

The majority of nurses perceived people with BPD as manipulative¹¹. Deans & Meocevic (2006) expressed concern about: how people diagnosed with BPD feel about the negative attitudes of the staff that care for them¹¹. In our study a significant percentage of staff that believed that individuals diagnosed with BPD are not mentally ill were mainly from the inpatient staff. Watts and Morgan (1994) in their important editorial in the British Journal of Psychiatry believed that feeling rejected by the clinicians is the basis for the development of "Malignant Alienation" which is a dangerous condition that is associated with high suicide risk and end with a fatal outcome¹².

Lack of service was the most important identified factor contributing to lack of care and the development of a specialist service was reported as the most important resource to improve care⁶. In our study the majority of responders indicated that BPD needs a special service. This may indicate that with the lack of skills and training in treating BPD, the specialist service is a preferred option. Whether this is a viable option or not? This would need to be objectively evaluated.

Special note:

While working in the Arab World 20 years ago, we did not see much of the BPD and our main source of knowledge at that time was essentially from western textbooks. Recently colleagues practicing in the Arab World spoke with me about the increasing numbers of individuals presenting with BPD. I spoke with colleagues practicing in various Arabic countries including Egypt, Saudi Arabia and United Arab Emirates who confirmed this phenomenal change. This would invite Arab Mental Health Professionals to study this phenomenon, which reflects a cultural change. There is an important opportunity for work to be done in this area both in prevention and in therapy. We should be able to learn from the western countries and other countries who are struggling to handle this problem inspite of dedicating huge resources including emergency admission in crisis situations, therapeutic community settings, individual and group psychological therapies and pharmacotherapy. What the west failed in, was essentially the preventive approach and how to prevent the society from generating more BPD. There is certainly less emphasis on promoting family values, social cohesion and religious teaching. Additionally, the alarming spread of substance misuse has direct

and indirect effects on childhood adversities, which in turn, contribute to pathological upbringing.

Sadly the statistics coming from Arab countries are alarming as well with divorce rates reaching 40 – 50% in countries that were well known with their cohesive families and low divorce rates.

I am calling upon experts in sociology; psychology and psychiatry to start jointly working now before it is too late. We need Pan-Arab studies of the epidemiology, presentation, management and more important developing a preventive strategy. In addition we need to evaluate the current service and training needs to meet the unmet needs of those individuals already diagnosed with BPD.

Conclusion: The study results indicate that many clinicians experience significant difficulty while working with BPD. Clinicians who attend training workshops seem to have a positive experience while working with BPD. There are training needs to be addressed. Arab Mental health professionals may find important lessons to learn and mistakes to avoid from the experience of mental healthcare organizations with BPD in western countries.

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الملخص

يعد اضطراب الشخصية من الأجزاء الهامة في التقسيمات التشخيصية المعاصرة , وقد لا توجد صعوبات كبيرة في مسألة التشخيص ولكن التحدي الأكبر هو في مجال التعامل الاكلينيكي مع هذه الحالات وقدرة خدمات الطب النفسى على سد الإحتياجات المتنامية لهؤلاء الأشخاص مما قد يتطلب تدريبات ومهارات اكلينيكية خاصة وربما خدمات طب نفسيه متخصصه. والبحث الحالى يتناول القدرات التشخيصية والمهارات العلاجية وخبرة الاكلينيكين في التعامل مع هذه الحالات في الغرب. وهنا نطرح بقوة أسئلة هامه عن نفس التشخيص في العالم العربى: ما نسبتهم, كيف يتم التعامل معهم من قبل خدمات الطب النفسى والإكلينيكين العرب, وهل هناك احتياجات تدريبية وخدمية؟ وبالإضافة إلى ذلك: هل هناك اهتمام كاف بهذه القضية الهامة في البحوث العربية ونشرها؟ إننا بحاجة ماسة لأن ندرس الخبره الغربية في هذا المجال بسلبياتها العديده وإيجابياتها المحدودة لنبدأ في بناء برنامج وقائى لمنع استفحال وتعاضم هذه المشكله والذى يتطلب تعاون المتخصصين في كل المجالات من العاملين في العالم العربى والمهجر. والله الموفق لنفع مرضانا ومهنتنا وأمتنا.

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Figures

Table 1:

Psychiatrists		Consultants		SAS		SHO			
Total targeted	Total answered	T	A	T	A	T	A		
47	40 (85%)	18	15	14	12	15	13		
Community		Nurses		OT		Psychologists		SW	
Total targeted	Total answered	T	A	T	A	T	A	T	A
150	98 (65%)	95	60	15	10	5	3	3	2
5	5								
Inpatient		Nurses		OT		Psychologists			
Total targeted	Total answered	T	A	T	A	T	A		
72	47 (65%)	60	40	8	4	4	3		
Total	Answered								
269	185 (69%)								

Target sample & responders

SAS: Staff Grade & Ass specialist doctor, SHO: senior house officer

SW: social worker, OT: occupational therapist

T: targeted, A: answered

Fig 1: Clinicians' self rated ability to diagnose/identify BPD

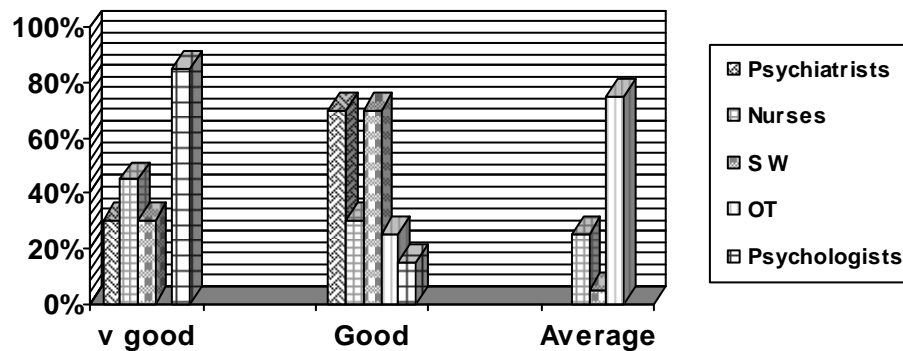


Fig 2: Preferred Diagnostic System



Fig 3: Clinicians' self rated ability to manage BPD

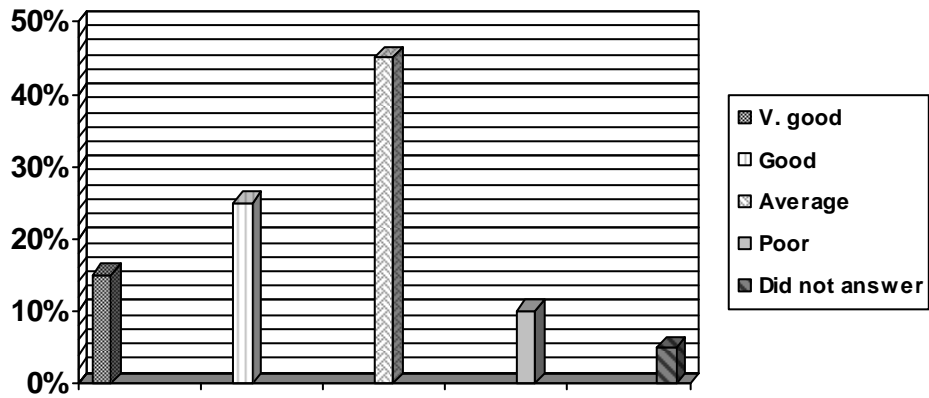
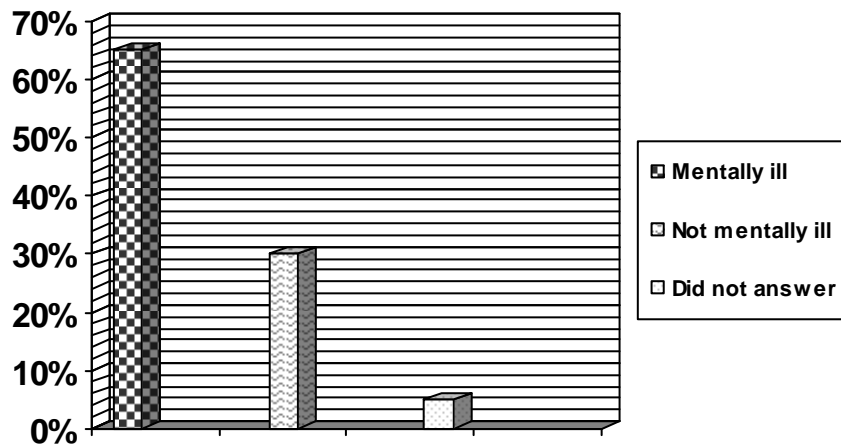


Fig 4: Clinicians experience of working with BPD



Fig 5: Clinicians's view of individuals with BPD



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