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Managing borderline personality disorder and substance use

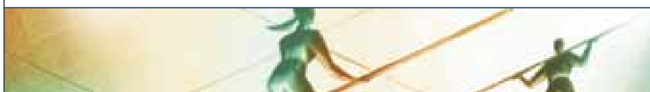
An integrated approach

Background
Although substance use is a common feature of borderline personality disorder, regular use is associated with greater levels of psychosocial impairment, psychopathology, self harm and suicidal behaviour and leads to poorer treatment outcomes. Management of co-occurring substance use disorder and borderline personality disorder within primary care is further compounded by negative attitudes and practices in responding to people with these conditions, which can lead to a fractured patient-doctor relationship.

Objective
This article provides an overview of how the general practitioner can provide effective support for patients with co-occurring borderline personality disorder and substance use disorder, including approaches to assessment and treatment, the therapeutic relationship, referral pathways and managing risk and chronic suicidality.

Discussion
Despite the complexities associated with this population, GPs are ideally placed to engage patients with co-occurring borderline personality disorder and substance use disorder in a long term therapeutic relationship, while also ensuring timely referral to other key services and health professionals. To provide the most effective responses to this patient group, GPs need to understand borderline personality disorder and its relationship to substance use, develop an 'explanatory framework' for challenging behaviours, implement mechanisms for reflective practice to manage negative countertransference, as well as learn skills to respond adequately to behaviours which jeopardise treatment retention.

Keywords: borderline personality disorder; substance use; drugs; alcohol; treatment



While population surveys reveal that around 1–2% of the general population meet the criteria for borderline personality disorder (BPD),[1] the prevalence of BPD within primary care is about fourfold higher, although many of these patients are not recognised as having an ongoing mental health problem by their general practiitoner.[2] Alcohol and drug use is common among this population, with between 21–81% reporting a co-occurring substance use disorder (SUD), and up to 65% of substance users in treatment meeting the criteria for BPD.[3] Such figures are concerning, as patients with co-occurring SUD and BPD present considerable challenges for both primary care and drug treatment services, given their association with greater levels of psychosocial impairment, psychopathology, substance use, unsafe injecting, self harm and suicidal behaviour.[4,5] Treatment studies also highlight that patients with co-occurring SUD and BPD have higher rates of relapse, treatment noncompliance and poorer outcomes than those with either diagnosis alone,[6] while SUD significantly reduces the likelihood of clinical remission of BPD.[7]

Complexities inherent in the treatment of co-occurring SUD and BPD are further compounded by negative attitudes and practices on the part of health professionals in responding to people with these conditions. This is especially evident in the context of substance use, where undiagnosed BPD may underlie a difficult patient-doctor relationship and delay access to appropriate treatment. Although stigma associated with this patient group is high,[8] such attitudes most likely reflect a lack of skills and knowledge in relation to the specific needs of this population, as well as the negative countertransference commonly experienced in working with these patients.[9] Indeed, it has been suggested that individuals with BPD constitute the 'most psychologically challenging patients a primary care physician ever encounters', and this is especially true when substance use is also prominent.[10]

Despite the complexities of this population, GPs are ideally placed to engage patients with BPD and SUD in a long term therapeutic relationship characterised by warmth, containment and hope, while also ensuring timely referral to other key services and health professionals. In order to provide effective support for this population, it is important that practitioners understand BPD and its relationship to substance use, and develop an 'explanatory framework' for challenging behaviours, mechanisms for reflective practice to manage countertransference, as well as skills to respond adequately to behaviours which jeopardise treatment retention.

Why do BPD and SUD commonly co-occur?

Many of the core features of BPD are also independent risk factors for the development of SUD, and it is therefore not surprising that these conditions commonly co-occur. For example, both impulsivity and affective dysregulation have recently been identified as key vulnerability factors in the development and maintenance of addictive disorders.[11] In addition, while the interaction between childhood trauma and poor attachment are frequently implicated in the aetiology of BPD,[9] clinical studies identify high rates of trauma (and associated post-traumatic stress disorder) among patients with SUD presenting to treatment services.[12,13] Such high rates of trauma may explain the high rates of BPD among patients with SUD within treatment settings, and the heavier patterns of substance use among those with SUD who have experienced trauma, particularly when faced with stressful or negative emotional situations.[13]

Management in primary care

Assessment and diagnosis

Patients with co-occurring BPD and SUD are highly likely to attend primary care, although the form of presentation is unlikely to be straightforward. Given the high rates of comorbidity with other mental disorders, patients may initially present with:

- symptoms of depression or anxiety
- suicidal ideation
- physical complications of their substance use, or
- difficulties in their relationship or workplace.

Early identification is preferable, given the many costs associated with delays in diagnosis, and it is therefore important that practitioners are familiar with the clinical characteristics (*Table 1*) as well as the risk of associated negative countertransference (see below).

Giving a patient a diagnosis of BPD can be both a liberating (the patient has a clearer understanding of themselves and how things can change) and at times damaging (the patient is stigmatised by service providers and excluded from treatment) experience. However, despite such stigma, appropriate diagnosis can enable accurate psychoeducation, guide appropriate treatment and avoid damaging treatment responses such as inappropriate prescribing and extended inpatient admissions. Nevertheless, it can be challenging to make a definitive diagnosis of BPD in the context of SUD as many common features of BPD (eg. impulsivity, dysphoria, emotional lability, self destructive behaviours, poor interpersonal relationships, poor sense of self) are also prominent in patients with SUD. In addition, regular, heavy substance use can lead to marked changes in a person's affect, personality and behaviour, particularly if they have a chaotic pattern of using, regularly consume both stimulants and depressants, and/or oscillate between periods of intoxication and withdrawal.

Table 1. Clinical characteristics that can help identify a person suffering from borderline personality disorder
Multiple self injurious acts (eg. cutting, burning, overdosing), recurrent suicidal attempts, gestures and threats
Chronic suicidal ideation
Poor self concept or self image – often these patients dislike themselves intensely and some may have body image issues
Stormy interpersonal relationships, intolerance to loneliness
Emotions: dysregulated, hyper-reactive, anger outbursts, anxiety and chronic dysphoria
Often attracts dysfunctional relationships
History of sexual abuse, neglect, invalidating backgrounds
Fear of rejection/abandonment
Experience numerous crises and have chaotic lifestyle
Transient, stress related paranoid ideation and/or dissociative episodes
Marked impulsivity (eg. excessive spending, engaging in unsafe sex, substance abuse, reckless driving, binge eating)

Diagnosis should include gaining collateral information and a longitudinal perspective (preferably following a period of abstinence). Providing psychoeducation to patients and family members about the diagnosis and the interaction between BPD and SUD is particularly important. The therapeutic relationship is likely to be more effective if there is a shared understanding between patient and practitioner about the aetiology of both disorders, including a biological and psychosocial formulation of their development, and how any challenging behaviours and internal experiences are triggered and maintained.

Building a therapeutic relationship

A positive therapeutic relationship plays a central role in the management of both BPD and SUD. In psychotherapies for this disorder, the therapist provides a relationship that helps identify and break the self defeating interpersonal patterns characteristic of previous relationships.[14] Giving the patient every opportunity to identify and change their maladaptive interpersonal patterns and learn new interpersonal skills to form healthy relationships constitute an important

part of any treatment. In this regard, clinicians should seize every single interpersonal opportunity to build up the skill level of this patient group.

Issues in the therapeutic relationship are best anticipated and addressed up front before behaviours that interfere with treatment (eg. frequent nonattendance, repeated crisis presentations) or interpersonal difficulties damage treatment retention or progress. A key aspect of the GP's role is to embody the potential for change and hope, while anticipating and responding to difficulties with the therapeutic relationship. In this context, it is important to recognise that change is likely to be slow and preventing serious harm can be an important focus of treatment. However, finding the balance between empathic validation and working toward behaviour change is incredibly challenging. Responding flexibly and moving along this continuum, while maintaining boundaries and responding to risk of harm, is essential in maintaining an effective therapeutic alliance, which gently but persistently moves the patient toward change. Key principles in the response to patients with chronic interpersonal difficulties are discussed by many therapy styles. The main characteristics that embody the ideal style of therapeutic relationship include:[15]

- empathy
- compassion
- curiosity
- collaboration
- respect
- openness
- connection, and
- authenticity on the part of the treating practitioner.

Recognising negative countertransference

Negative countertransference (the unconscious development of negative feelings toward the patient on the part of the clinician) is common when working with patients with BPD – and in fact should be expected – particularly when complicated by SUD. Working successfully with patients with BPD and co-occurring SUD requires many layers of support in order to prevent any negative countertransference adversely impacting treatment planning or the response to crisis presentations.

Practical strategies that GPs can readily implement include:

- clinical or collegial supervision to discuss negative countertransference
- responsibility of client management lying with a team of service providers and not individual practitioners
- external secondary consultation when treatment is not progressing
- appropriate practice policies and procedures to manage difficult behaviours in the waiting room, and
- support from your practice colleagues to review treatment planning, help identify blind spots, offer alternatives, validate your efforts, and hold hope for change.

Clinicians should also be aware of the potential for romantic countertransference and should seek advice and assistance from a senior colleague or a psychiatrist in the first instance.

Staying focused on the underlying needs of the patient

Overcoming frustration and avoiding reacting with a rejecting or judgmental response is difficult, but can be achieved by maintaining focus on the underlying needs of the patient. To this end, GPs should develop an explanatory framework for why people with BPD and SUD appear to self sabotage treatment, purposely damage the therapeutic relationship and have difficulty with motivation. Ongoing self reflection is essential in maintaining this framework. The practitioner's role in helping the patient to develop less destructive ways of relating to others and assissting them in accessing treatment is critical. In this regard, it is important that GPs have an understanding of the underlying experience of BPD co-occurring with SUD. The ongoing and daily difficulties as described in *Table 1* make engaging appropriately in a therapeutic relationship extremely difficult. An overly reactive emotional system, combined with an inability to regulate these extreme emotional experiences, is central to the underlying experience of BPD. This dysregulation of emotion is often experienced by patients with BPD as intense highs and lows that feel intolerable and unrelenting, with substance abuse being a key coping strategy. Recommendations for the treatment of patients with BPD and SUD are listed in *Table 2*.

Table 2. Recommendations for treatment of patients with BPD and SUD within the primary care setting[2]
Ensure early detection and referral to mental health service or psychiatrist for psychotherapy
Address the co-occurring SUD, including relevant pharmacotherapy or referral to specialist drug treatment
Actively treat any co-occurring mental disorders (eg. major depression)
Educate patient and family about the diagnosis
Show interest and concern in the patient while maintaining clear boundaries
Acknowledge the patient's feelings, but be clear that you will only tolerate appropriate behaviour at the practice
Defuse any potential confrontations by remaining calm and neutral
Prescribe wisely (eg. frequent dispensing such as weekly; a single identified pharmacy; trials of medication linked to clearly defined outcomes; avoid polypharmacy; prescribe opiates and benzodiazepines with caution)
Schedule regular structured appointments
Develop a crisis management plan with the patient
Have a chaperone present when conducting physical examinations
Ensure frequent communication between all treatment providers to avoid splitting (ie. playing one practitioner against another)
Engage in clinical supervision or case review with a colleague

Treatment contracting

Treatment contracting can be useful with patients who have BPD, especially if done with consideration and reflection. Treatment contracting, unlike informed consent, is a negotiation between you and the patient about the expectations of each other during the course of treatment, and indicates both you and the patient share the responsibility for treatment. Together, you should both identify the goals, purpose and practical arrangements of treatment (such as frequency of appointments). Treatment contracts should not be seen as punishment for poor behaviour, but an opportunity to address motivation, elicit commitment, as well as establish clear expectations and boundaries.[16]

Referral for long term psychotherapy

Given the complexity of issues inherent in co-occurring BPD and SUD, referral for longer term psychotherapy with a psychiatrist and/or clinical psychologist is an important consideration in treatment planning. Indeed, there is good evidence for recovery from many of the more debilitating aspects of BPD and SUD, such as chronic self harming, with adapted cognitive behaviour therapy (CBT) approaches such as dialectical behaviour therapy (DBT).[17,18] Similarly, psychoanalytical therapy adapted for co-occurring BPD and SUD (eg. dynamic deconstructive psychotherapy [DDP]) has been shown to be effective.[6] Importantly, studies of co-occurring SUD and BPD have demonstrated comparable treatment outcomes to SUD alone as long as patients remain in treatment. However, treatment adherence is an obvious challenge for patients and significant support and management is usually required to retain patients in treatment once initial crises have resolved. Referral to specialist alcohol and drug treatment for ongoing counselling, detoxification or rehabilitation should also be considered, while self help groups such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) can provide additional support.

Family members may also require referral for support as the impact of having a family member with co-occurring BPD and SUD cannot be underestimated. Children of patients with this presentation are particularly vulnerable. It is therefore advisable that family members receive treatment from different practitioners to avoid any potential conflict of interest or ethical dilemmas.

Medication

While psychotropic medications are very commonly prescribed by health professionals for patients with BPD, there is limited evidence to guide rational pharmacotherapy and it is best to make a collaborative decision with the patient around medication.[19] There is no current medication that is approved for the management of BPD, although there is some evidence that low dose atypical antipsychotics and/or mood stabilisers may be effective in treating core symptoms. Antidepressants should only be prescribed for the treatment of comorbid major depression and polypharmacy is best avoided,[20] particularly as 25% of patients with BPD may consider suicide by overdosing on medications.[21] Patients with BPD and co-occurring SUD often seek medications to address their underlying difficulties. In response, GPs (and other clinicians involved in their care) should regularly emphasise the need for nonpharmacological approaches to these problems. Making this explicit in the treatment plan can help ensure that discussions regarding medications do not become a focus of future consultations. Pharmacotherapy for alcohol or opiate dependence should be pursued in patients with co-occurring BPD and SUD if appropriate (eg. anticraving agents or opiate substitution pharmacotherapy).

Opioids or benzodiazepines should be prescribed with caution as they are more likely to result in aberrant use and dependence among patients with BPD. If these medications are needed, measures to reduce risk need to be put in place. This includes an agreed plan for ceasing medications before their commencement, prescribing for limited periods of time, frequent dispensing (eg. weekly), and a single identified pharmacy. Trials of medication, linked to clearly defined outcomes, should form part of a care plan that is integrated into the treatment contract. Gourlay et al's 'universal precautions' for prescription medications are particularly relevant in this context.[22] Indeed, it is important that practitioners do not to unwittingly contribute to the development or maintenance of SUD in this group of patients.

A coordinated approach

Ongoing communication between all treatment providers is essential for a coordinated treatment approach and a designated case coordinator, who is responsible for managing communication between professionals, is recommended to ensure splitting does not occur. Splitting is a defence mechanism often experienced by BPD patients, and is usually the result of the patient's efforts to get rid of unbearable inner emotional experiences. This can lead to the patient having polarised views about different members of the treating team. In turn, team members may develop polarised views about the patient (ie. being 'all good' or 'all bad'), resulting in conflict over the treatment approach. Splits often occur along pre-existing divisions between treatment providers, therefore it is essential that splitting is identified early and processed. Regular communication and supervision can assist in resolving and managing splitting effectively.

Risk management and chronic suicidality

The nature of BPD is such that a valid risk assessment is very difficult to conduct without knowing the patient's prior history or being involved in crisis presentations over time. While it is obvious that patients with BPD are often chronically suicidal, there is a significant risk of successful suicide, especially when there is a co-occurring SUD. Finding a balance can be difficult, and cannot be done in isolation from your ongoing therapeutic relationship with the patient. Clinical judgment needs to take into account whether the current suicidal presentation represents a risk over and above the usual chronic presentation of the patient (*Table 3*). Worrying factors

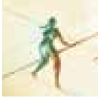


Table 3. Strategies for GPs to assist in the management of crises in patients with BPD and SUD[23]
Conduct thorough risk assessment, using known factors relating to risk for the patient, with particular attention to intoxication
Use clinical judgment in the context of past suicidal presentations
Explore the problem in the immediate timeframe by identifying key events which led to the emotional state and sense of crisis
Formulate and summarise the problem
Help the patient commit to a crisis management plan
Focus on problem solving
Attend to the emotion rather than the content
Provide education, give advice and make suggestions
Identify factors interfering with a productive plan of action (eg. anticipate substance misuse)
Reinforce adaptive responses to crisis
Predict positive future response to the crisis management plan
Reinforce harm reduction for substance use
Remove, or instruct patient to remove, lethal items identified in a suicide plan
Emphatically instruct patient not to commit suicide
Maintain a position that suicide is not a good solution
Generate hopeful statements and solutions
Validate treatment progress
Keep in contact with the patient when suicidal risk is higher than usual
Anticipate recurrence of crisis response
Widen service strategies
Refer to psychiatric triage and area mental health crisis and assessment team
Notify all treatment providers
Notify family members when warranted
Engage other service providers and family members (where appropriate) in risk management plan

include an increase in the intensity of the affect associated with the crisis, withdrawal of usual social supports, and escalating alcohol and substance use.

The management of chronic suicidality in patients with BPD and SUD carries a significant risk of burnout and 'empathy fatigue' in treating practitioners, therefore collegial support, case review and secondary consultation are essential in supporting practitioners to remain involved in treatment in the long term. It is important to remain mindful that under-response to suicidal presentations may occur when practitioners become desensitised to suicide. Strategies for GPs to assist in the management of crises in patients with BPD and SUD are outlined in *Table 3*.

Summary of important points

- The prevalence of BPD within primary care is about fourfold greater than the general population, and alcohol and drug misuse is common among this population.
- Treatment outcomes are poorer and the risk of harm is greater for people with comorbid BPD and SUD.
- A positive therapeutic relationship plays a central role in the management of both BPD and SUD.
- Positive management within primary care should be informed by an understanding of BPD and its relationship to substance use.
- An 'explanatory framework' for challenging behaviours, mechanisms for reflective practice to manage countertransference, and skills to respond adequately to behaviours which jeopardise treatment retention are recommended.
- Opioids or benzodiazepines should be prescribed with caution in this group of patients to avoid unwittingly contributing to the development or maintenance of SUD.
- Referral for long term psychotherapy, crisis management, treatment contracting, collegial support and clinical supervision are recommended.

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