CASE ONE

Short case number: 3_25_1
Category: Mental Health and Human Behaviour
Discipline: Psychiatry
Setting: Hospital ward
Topic: Personality Disorders – Borderline

Case

You are an intern working with the endocrinology team. The nurse asks you to see a 21-year-old woman, Kate Lohan, admitted the previous day under Dr Singh's care for stabilisation of her diabetes following an insulin overdose . Kate's blood sugar has stabilised with minimal intervention, as it usually does. When she presented to the emergency department she told the ED staff she wanted to die and was trying to end her life.

On the ward the nurses are becoming increasingly frustrated and angry as this is Kate's 9th admission for a similar reason in the last four years; they feel that Kate intentionally alters her insulin doses. They do not think that she deserves to be in hospital ("this only reinforces her behaviour") and they want you to discharge her ("she is keeping a bed that could be used to treat people who will benefit more and are kept waiting in a trolley in ED").

Questions

1. How would you assess Kate's mental state and risk? What questions would you ask to clarify the intention of her overdose?

After interviewing Kate you learn she was diagnosed with depression as a teenager after her first insulin overdose. She has tried 4 different antidepressants but says "none of them make me feel much better. She denies suicidal ideation at present but doesn't know how she'll feel when she gets home, as she is fighting with her mother at the moment. The main issue Kate wants to talk about with you is her problem with the treatment she has received from two particular nurses who she says have been late taking her blood sugars. She reports Dr Singh has told her she needs to have these done on time and will not be happy when he hears about this. On your assessment there are no signs to suggest a major depressive episode.

2. What is your immediate and short-term management plan for Kate? Who will you will need to involve to make this management plan? How would you address the nurses' concerns?

After collecting collateral information and speaking to the consultation liaison psychiatry team, you learn Kate has a diagnosis of Borderline Personality Disorder, but that no-one has discussed this with her.

3. How would you explain the Borderline Personality Disorder diagnosis to Kate?

4. What would be your long-term management plan for Kate? Include some discussion about the evidence based treatment options for Borderline Personality Disorder.

Questions to clarify intention of her overdose?
Need to determine - was it a suicide attempt or non suicidal self harm (AKA Para-suicide)

Start general
1. Some people feel like ending their life when they feel very down - does this apply to you?

Get Specific about this event?
- When you tool the insuin what did you expect to happen
- Did you take it to die or because you wnated the emotional pain to stop
- Was this something you planned or just did on the moment
- Pattern of self harm vs suicidlity
- Do you ever harm yourself in ways not intended to end your life
- What stopped you from taking more or doing something different

Weave this into talking about what has been going on in the last few weeks and not just suicide, suicide, suicide.

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Classic BPD: This is her life playing out unconsciously on the wall, she is transfering the negative feelings about her mum onto the nurses (so the nurses are bad) and the doctor (who may represent her father) is brilliant and ant do anything wrong.

Immediate short term management plan + who is involved:
1 Safety + Stabilise
2 Psychiatric Assessment
3 Therapeutic Engagement
4 Admission Strategy (prolonged admissions can exacerbate BPD symptoms, however if we send her home, she will be back with mum, this will set her off again, so maybe best to admit her somewhere so she has time to work through these things).

Involve: MDT, Pt, Family/Support Person, Psychologist, Social Worker/Case Manager, GP

Explain BPD Dx to Kate
Use SPIKES

What it is: BPD is..... Combination of genetic and environmental impacts - childhood experiences teach us how to be

Not your fault: Its a brain mind condition, you did not cause it

Prognosis: With support & treatment, many people go on to have meaningful relationships and happy lives

Treatment: DBT, Medications, Relapse Prevention, Safety Planning

Collaborative Plan: We will work with you to support you

Next Steps Today:...

Info on BPD:

BPD is cluster B (Dramatic, emotional erratic)
10% all personality disorders, 6% prevalence
Combination of genetic and environmental impacts - childhood experiences teach us how to be

Fucked childhood experiences
often result in fucked development then
getting a personality disorder
with a fucked sense of self

Management for BPD

- 1st Line - DBT (Dialecical Behavioural Therapy) -*Needs at least 24 months of sessions to be beneficial*
- MBT (Mentalisation-Based Treatment)
- Adjunct Medications (SSRIs)
- Relapse Prevention
- Crisis Management
- Smoking & Substance abuse support

Resources

1. **About DBT see http://behavioraltech.org/resources/tools_clinicians.cfm**
2. **Project Air: A Personality Disorder Strategy https://www.projectairstrategy.org/index.html https://bpdfoundation.org.au/images/ProjectAir_Treatment%20Guidelines.pdf**
3. **Carter, G., Page, A., Large, M., Hetrick, S., Milner, A. J., Bendit, N., ... & Burns, J. (2016). Royal Australian and New Zealand College of Psychiatrists clinical practice guideline for the management of deliberate self-harm. Australian & New Zealand Journal of Psychiatry, 50(10), 939-1000. https://www.ranzcp.org/practice-education/guidelines-and-resources-for-practice/self-harm-cpg-and-associated-resources**
4. **Harrison, P., & Fazel, M. (2017). Shorter Oxford textbook of psychiatry. Oxford university press. Chapter 21: Suicide and self-harm.**
5. **Framework for Suicide Risk Assessment and Management for NSW Health Staff. https://www.health.nsw.gov.au/mentalhealth/resources/Publications/suicide-risk-assess-comm-mh-service.pdf**
6. **Stern, Theodore A., et al. Handbook of General Hospital Psychiatry, Elsevier, 2017. ProQuest Ebook Central, https://ebookcentral.proquest.com/lib/unda/detail.action?docID=5252990. Chapter 43: Difficult Patients.**
7. **Dimeff, L., & Linehan, M. M. (2001). Dialectical behavior therapy in a nutshell. The California Psychologist, 34(3), 10-13.**
8. **Biskin, R. S., & Paris, J. (2012). Management of borderline personality disorder. Cmaj, 184(17), 1897-1902.**
9. **RANZCP, Your Health In Mind. https://www.yourhealthinmind.org/getmedia/e4a256bf-e2b8-4870-8ee5-54fd0a1d3acc/Borderline-personality-disorder-YHIM.pdf.aspx?ext=.pdf**

ANSWERS

1. **How would you assess Kate's mental state and risk? What questions would you ask to clarify the intention of her overdose?**

   Need to build rapport and therapeutic alliance with Katie – introduce yourself, explain confidentiality and its limits, be open to hearing Kate's concerns but be careful not to 'take sides' with her against the other medical and nursing staff: just listen.

   Take a history:
   Presenting symptoms
   - Circumstances surrounding overdose –
     - Planning or impulsive overdose?
     - Triggers / stressors for this overdose – similar or different to past overdoses?
     - Wish to be dead
     - Expectation about outcome of self-harming behaviour or suicide attempt/threat
     - Length of time suicidal feelings have been present.
     - Regret/remorse over current/previous attempt
     - Mental state at time of self-harm or suicide attempt or threat (alcohol or drug intake, social situation, relationship changes, bereavements)
     - Plans for others after death: suicide notes, changes to will, consequences
   - Specific plans to end life now
   - Lethality and frequency of plans or attempts
   - Other self-harming behaviour
   - Feelings of hopelessness / worthlessness / guilt
   - Assess current suicidal intent/wishes
   - Assess for current symptoms to suggest a mood disorder
   - Ask Kate about recent emotional experiences – has her mood been fluctuating.
   - What are usual coping strategies when feeling suicidal?

   Other history
   - Past psychiatric history – Diagnoses / treatments / treatment providers / admissions / pattern of past overdoses.
   - Medical history: How does Kate usually manage her diabetes? Does she have any complications to suggest poorly managed diabetes, concerning HBA1C levels
   - Social support or problems
   - Relationship issues
   - Skills, strengths and assets
   - Psychosocial and occupational functioning
   - Personal and financial difficulties
   - Timeline / developmental history

   Complete a mental state exam
   - Can Kate be engaged in the review? Are you able to build rapport?
   - Is Kate able to give a good / clear account of what happened?
   - What are Kate's mood and affect?
   - Are there any psychotic symptoms present?
   - Is Kate's cognition clear?

History and mental state examination may help to differentiate whether Kate's presentation is due to a suicide attempt and non-suicidal self-harm.

- Self-harm means any behaviour that involves the deliberate causing of pain or injury to oneself. This includes cutting, burning or hitting oneself, overdosing on prescription or illegal drugs, among others.

- Non-suicidal self-harm is usually a response to distress —often the distress is associated with mental illness or interpersonal problems. In the short-term, some people report that cutting, burning or hitting oneself provides temporary relief from the psychological distress they are experiencing. In other cases, self-harm is a way of seeking care or of getting out of intolerable situations or emotional conflicts.

- People who self-harm repeatedly have episodes in which the self-harm is not suicidal (e.g., it is performed to release stress, to feel the pain, to feel 'real') and episodes in which the self-harm is suicidal. In all cases, repeated self-harm suggests that the patient requires careful professional help.

Questions to assess suicidal intent

- Usually start with general questions e.g.
  "Have you ever felt that life is not worth living?"
  "Sometimes people who feel that way try to kill themselves. Have you ever felt that way?"
  Describing things in the third person ("Many people who feel upset often think of killing themselves. Have you ever felt like that?") is often more effective and perceived by patients as less threatening or critical.
- Move to the concrete questions about what happened e.g.
  "Diabetic patients who go through a difficult patch might overdose in insulin. Is that what happened?"
  "When you took the overdose, did you think you might die?"
  "Did you make a plan to take the overdose, or was it a spur of the moment decision?"
  "Are you still thinking of ending your life?"
- If the intent was suicidal, it is important to clarify the seriousness of the intention and the likelihood or repetition in the short term.
  "How do you feel about being alive now?"
  "Have you been thinking about trying to harm yourself again?"
  "Have you made a plan to end your life?"

2. What is your immediate and short-term management plan for Kate? Who will you will need to involve to make this management plan? How would you address the nurses' concerns?

Immediate management plan:

- Ensure safety – Kate is not currently suicidal but may have increased suicidality at times of stress / interpersonal conflict e.g. conflict with nurses or mother if she comes to visit.
- Make sure there are no easily accessible ways to harm herself at the bedside – scissors / insulin pens etc.
- Does not need a special 1:1 nurse at present, but something to consider if she becomes very distressed / suicidal.

- Build a therapeutic alliance – in this case this does not mean siding with Kate again the nursing staff, but rather listening to her concerns and acknowledging her emotions, while also reinforcing the role the nurses have in caring for her.
- Make sure diabetic management is optimised.
- Review Kate's past notes – what has happened in hospital before, who else has been involved, what has helped previously.
- Make a referral to Consultation Liaison psychiatry
- Think about if the Mental Health Act is needed - in discussion with mental health team, where it seems there is high risk – hopefully it can be avoided in Kate's case and she can be engaged in treatment.

Short term management plan:

- Arrange a meeting with endocrinologist / nursing staff / CL psychiatry to discuss a consistent approach to Kate's management in the ward setting.
    Aim to avoid splitting.
    Make a clear plan for when blood sugars will be taken and what the margin of error will be.
- Communicate the management plan to Kate, offer her support to understand the plan.
    - Discuss emotional regulation techniques Kate can use in the ward setting.

- Unlikely to benefit for an admission to a psychiatric ward – need to plan for Kate's discharge home.

- Planning for discharge
- Engage Kate in the planning – ask her about her thoughts on why has presenting to hospital and how she could be better supported at home.
- Teach Kate some distress tolerance skills to help in the short term.

Who needs to be involved in the plan:

- Mother
- Nursing staff
- Medical team – endocrinologist/ DM educator
- Mental health providers in the community – psychologist / GP / community mental health team

Think about options for who can help prevent further presentations.

Nurses concerns:
This is a good example of negative countertransference. The negative nursing staff responses can lead to an unplanned discharge, therapeutic nihilism, and an early recurrence of the same behaviour. Often patients like Kate, who feel rejected by a hospital or clinician, re-present quickly elsewhere with the same problem.

Negative comments by nursing staff (or medical staff for that matter) are opportunities to discuss and educate them about the needs and best way to manage patients with emotional instability and splitting. It needs to be acknowledged that patients like Kate can feel difficult to care for and may consume a lot of medical resources.

However, although the motivation for these patients' behaviour varies from case to case, rejection or punitive responses make the situation worse. Nursing staff should be informed of

Kate's problems (e.g., a description of the mental disorder [see answer to the next question below]) what is the overall management plan –not just of the medical problems associated with the treatment of her diabetes but also the management plan to deal with the psychological problems—follow up after discharge and strategies to minimise further overdoses and readmission.

3. How would you explain the Borderline Personality Disorder diagnosis to Kate?

Background information:

BPD belongs in Cluster B of the personality disorders (together with antisocial, narcissistic and histrionic) in the DSM 5 classification. The name "borderline" derives from originally believing to be at the "borderline" of psychosis. The disorder can lead to pervasive instability which often disrupts family and work life, long-term planning, and a person's sense of self-identity.

DSM 5 Diagnostic Criteria
A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Frantic efforts to avoid real or imagined abandonment. (**Note:** Do not include suicidal or self-mutilating behaviour covered in Criterion 5.)
2. A pattern of unstable and intense interpersonal relationships characterised by alternating between extremes of idealization and devaluation.
3. Identity disturbance: markedly and persistently unstable self-image or sense of self.
4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). (**Note:** Do not include suicidal or self-mutilating behaviour covered in Criterion 5.)
5. Recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour.
6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).
7. Chronic feelings of emptiness.
8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
9. Transient, stress-related paranoid ideation or severe dissociative symptoms.

Useful video of John Gunderson explaining the features of Borderline Personality.
https://www.youtube.com/watch?v=h15OnmUqFj8

The NHMRC Guideline suggests Australia has a population prevalence of 1-4%. Females have higher rates than males, and it is more common in younger people.

Explaining Borderline Personality Disorder diagnosis to Kate:
Principles:

- Chose the right time and setting to explain the diagnosis – make sure Kate is calm and able to engage in a discussion, allow enough time for a good discussion.
- Be open to questions
- Be empathetic
- Be honest about the diagnosis
- Use clear and patient centred language

- Allow for a hopeful stance – BPD is a serious mental disorder but is treatable
- Offer to resources for Kate to read more about BPD – Your Health in Mind from RANZCP, Project Air, Headspace etc.

Key things to discuss with Kate:

- Borderline personality disorder (BPD) is a mental illness that makes it hard for a person to feel comfortable in themselves, causes problems controlling emotions and impulses and causes problems relating to other people.
- People with BPD experience high levels of distress and anger.
- People with BPD can find everyday situations very upsetting.
- Things that other people do or say can feel very hurtful.
- BPD is a condition of the brain and mind. It is not the person's fault and they did not cause it.
- BPD is a treatable condition and most people with BPD can recover.
- Overcoming emotional problems, finding more purpose in life, and building better relationships are many people's main goals for their treatment.
- BPD is treated with psychological treatments (talking therapies). These usually involve talking with a health professional one-to-one, or sometimes attending special groups.
- Psychological treatment for BPD should be well-organised and pre-planned (structured), designed for people with BPD, and given by a health professional who is properly trained and supervised.
- Medication not recommended as a person's main treatment for BPD, but may be helpful to manage particular symptoms. (From Your Health in Mind, RANCZP).

As you talk about the features of the disorder with Kate, you can ask her if this fits with her experience or if she can this of examples from her own life.

4. What would be your long-term management plan for Kate? Include some discussion about the evidence based treatment options for Borderline Personality Disorder.

Create a Management Plan for diabetic care and readmission to hospital:
Because these patients present frequently while staff (e.g., residents, nursing) change regularly, it is also helpful to agree on a multidisciplinary management plan (involving endocrinologists, emergency dept. staff, consultant psychiatrist etc) to deal with re-admissions. This plan is kept in the medical file and gives clear guidelines, enhancing consistent management. When a plan is not available, problems arise, staff become inconsistent and negative responses are more likely.

Discuss aims of treatment with Kate which might include:

- to overcome emotional problems (such as depression, anxiety and anger)
- to find more purpose in life (e.g. by making a positive contribution to her community)
- to build better relationship with her mother
- to learn how to understand and live with herself
- to improve physical health and have better control her diabetes
- To learn how to reduce self-harming behaviours

Engage Kate's GP and family in her care and ensure they have access to resources and support

Treatments for BPD are psychologically based, medication is usually not recommended but is sometimes used to manage symptoms.

Discuss with Kate that all treatments have some things in common:

- Designed to solve typical problems for people with BPD and focus on helping them change.
- Structured: they are pre-planned, well-organised and have regular sessions (often based on a written manual that treatment provider follows)
- Ideas behind the treatment are clearly set out and explained.
- Relationship between patient and the person providing the treatment is an important part of the treatment.
- Patients are encouraged to take control of their life, and are involved in making plans for treatment.
- Treatment provider helps patient to understand how the things that happen to them are linked to their feelings.
- The treatment provider doesn't just listen, but responds to the patient's ideas and helps guide them to solve their problems.
- The treatment provider pays attention to the patient's emotions and accepts the experiences and feelings are real.

Evidenced based treatments in Australia / New Zealand.

- dialectical behaviour therapy (DBT)
- cognitive behavioural therapy (CBT) designed especially for people with BPD
- mentalisation-based treatment (or 'mentalisation')

Dialectical behaviour therapy (DBT)
(From the SANE website - https://www.sane.org/information-stories/facts-and-guides/dialectical-behaviour-therapy-dbt)

Dialectical behaviour therapy (DBT) is a modified version of cognitive-behavioural therapy (CBT) designed to treat borderline personality disorder (BPD). It can also be used to treat other conditions, like suicidal behaviour, self-harm, substance use, post-traumatic stress disorder (PTSD), depression and eating disorders.

How DBT works
The term 'dialectical' means 'working with opposites'. DBT uses seemingly opposing strategies of 'acceptance' and 'change'. The therapist accepts you just as you are, but acknowledges the need for change in order for you to recover, move forward and reach your personal goals.

During a course of DBT, the therapist works with you to help you move away from a chaotic life and towards a life that you find personally meaningful and fulfilling.

DBT involves developing two sets of acceptance-oriented skills and two sets of change-oriented skills.

Acceptance-oriented skills
Mindfulness
Learning how to focus your awareness on the present moment, and to acknowledge and accept your thoughts, feelings, behaviours and bodily sensations as they occur, without the need to control or manipulate them.

Distress tolerance
Learning how to manage and cope during a crisis, and to tolerate distress when it is difficult or impossible to change a situation. Learning to accept any given situation just as it is, rather than

how you think it should be, or want it to be. Learning new skills like distraction and self-soothing, for both coping with and improving distressing moments.

Change-oriented skills
Emotional regulation
Learning how to effectively manage your emotional experience, and not allow your emotions to manage you.

Interpersonal effectiveness
Learning assertiveness strategies to appropriately ask for what you want or need. Learning how to say no, and how to manage interpersonal conflict in a way that maintains respect for yourself and others.

A typical course of DBT
DBT is typically run as a 24-week program, often taken twice to create a one-year program. In its standard form, there are three ways you receive DBT during the program. There are also shorter versions of DBT such as 12 week courses depending on the setting, and some versions do not include telephone coaching. DBT has been adapted for different needs.

DBT skills training group
A group facilitator teaches specific skills in a classroom setting, and sets tasks for the group members to practise between sessions. The skills training group typically meets once weekly, usually for around 2½ hours, across the 24-week program.

Individual therapy
Running at the same time as the group, individual therapy typically occurs weekly to enhance your motivation and commitment to the program. It's also an opportunity to discuss and apply specific DBT skills to your current everyday life.

Between-sessions telephone coaching
On-the-spot telephone coaching from your therapist can be available at times during the week when you're struggling. Your therapist guides you and encourages you to apply your new DBT skills to address and manage your issues.