BORDERLINE PERSONALITY DISORDER – IT'S HERE TO STAY

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No matter how accomplished a therapist you become, there are patients that will always test your skills. People diagnosed with Borderline Personality Disorder (BPD) are often labeled as 'difficult-to-treat patients' and are notoriously difficult to manage, with each patient of BPD requiring a personalised management plan[1]. BPD affects around six percent of the world's population[2], however, no data is available for its prevalence in Pakistan. Compared with other mental health disorders, personality disorders tend to be woven in the very fabric of a person's being and are, thus, pervasive and resistant to change[3]. BPD is defined as a persistent pattern of instability of interpersonal relationships, self-image, affects, and marked impulsivity[4]. It begins by early adulthood and presents in a variety of contexts. The more common are frantic efforts to avoid real or imagined abandonment, recurrent suicidal behaviour / deliberate self harm, to chronic feelings of emptiness and affective instability[5].

In Pakistan, the assessment and management of BPD is often inconsistent, variable, and unscientific. Mental health professionals lack the time, knowledge and sometimes the skills that are needed to effectively address the needs of those diagnosed with BPD. This results in incorrect and unneeded treatment options with no improvement in symptoms, leading most therapists to label these patients as treatment resistant. This adds a considerable amount of burden on both the patient and on the health care system. There is also a lack of community surveys in Pakistan which could help determine the prevalence of BPD in the country. With gross paucity of human resource in the field of mental health, BPD, on account of repeated visits, often a poor response to treatment, and dramatic presentations can overburden and even overwhelm the mental health services in Pakistan. With little to offer except medication, the psychiatric services shift the burden to the already frustrated and sceptical family of the patient. The ill-equipped, ill- informed carers often resort to violence, ridicule, rejection, and sometimes even abandonment of BPD patients. This creates a need to raise awareness about the prevalence of the disorder, its accurate diagnosis and its evidence-based management.

One of the most glaring problems of patients with Borderline Personality Disorder is self-harm. These patients describe chronic feelings of emptiness leading to a feeling of numbness that is temporarily relieved by harming themselves, by cutting or other methods. Some of the patients describe an overwhelming feeling of emotions that bottle up within them, and the only way they find a release of these emotions is by deliberate self harm. This self harm sometimes leads to serious and life threatening consequences and repeated attempts result in frequent visits to the emergency department. After the acute management of the injury, the doctor-on-call usually refers the patient to a mental health professional who treats BPD seriously in the initial few visits, but eventually gets frustrated when the patient 'refuses to get better'. This frustration results in a change in behaviour of the therapist towards the patient, resulting in solidifying the belief of the patient of being rejected once again, just as they have been rejected throughout their life. Their faith in the mental health profession is lost, and so is their only hope at receiving help. There is also a lack of support groups in the country. The realisation that you might not be going through it alone and that there may be others within the community who think and feel like you do is a leap towards a positive mental health.

Furthermore, two important stakeholders in the care process of BPD remain unattended at their own peril as much as that of their patient. The therapists and families of patients with BPD are also in dire need of support and understanding. Both continue to suffer in silence while the patient's state does not improve. The therapists working with BPD patients need constant support from the mental health community. Such support can help them achieve a better understanding of their negative counter-transference and the role of therapist-related factors that may so often impede progress in BPD patients.

In light of the current situation, a committee of mental health professionals has convened in Rawalpindi, to form a BPD interest group. Through monthly meetings of mental health professionals from home and abroad, the group aims at creating a deeper understanding of the subject of BPD, and also develop a culturally relevant manual that can help standardise the management of BPD patients across Pakistan. In it's initial discourse on the subject, the Rawalpindi interest group on BPD has developed a consensus on some basic principles that will form the basis of the manual for management of BPD in Pakistan. The interest group agrees on the following key points:

- Assessment, evaluation and suitability for manualised structured care, must be based on a stringent diagnostic, inclusion and exclusion criteria. The assessment must include a special concern for physical, emotional and sexual abuse, childhood attachment styles/ related issues and adverse childhood experiences (ACEs).
- The relationship between the patient and the mental health professional engaged in management may be based on the Dialectical Behaviour Therapy model of a teacher- taught relationship. This is primarily to prevent the high risk of negative counter transference amongst the therapists engaged in psychotherapeutic relationship with patients of BPD.
- A family based approach where the significant others and family members are engaged alongside the patient as active participants in the care and therapeutic plan is supported.

Exclusion of family from therapy may be counterproductive. One or several members of a family may start to get affected while help is being extended to the patient. Support and facilitation to a family member who is decompensated is considered part of the therapeutic process. In addition, the therapeutic process must include interventions starting with family counselling, psychoeducation and informational care to remove misconceptions and reduce stigma. An early identification of counterproductive / maladaptive coping strategies in the family, crisis genesis and development alongside, and teaching of skills to family to resolve conflicts and crises may prevent relapses in the patient.

- Learning of adaptive and unlearning of maladaptive behaviours remain the key objective of treatment. The therapists may utilize metacognitive and other evidence based methods of enhanced learning to achieve behavioural changes in the patient, who may not adhere to simple advice, counsel, home tasks, behaviour activation, and other attempts of participation in the therapy.
- Patients of BPD and their families may present with a plethora of issues and challenges. To ensure greater success, the patient and the therapist may develop a list of high priority and urgent issues, and deal with them exclusively in the first go. Attempts at 'sorting out everything' that has gone wrong in the eyes of the patient, may frustrate the therapist, and fail eventually.
- A therapist must aim to create an air of sincerity, unconditional regard, and empathy. We must avoid criticism, cynicism and sarcasm in the therapy sessions. Patients of BPD may prematurely opt out of treatment settings with earliest signs of the latter.
- The therapy must proceed with a constant collaboration of the patient, family and the therapist. All possible techniques to ensure a healthy flow of information, reliance and support of each, use of examples and phrases familiar to the patient or used frequently by him or her, preparation of flow charts, mind maps, may be prepared during the sessions and as home work to improve learning. A profuse use of role plays, and re-enactment of difficult situations at home and in social settings that serve as triggers for morbid behaviour may also help in the eventual success of therapy.
- The principles of reflection and experiential learning (observe, assist, perform) may enhance the social skills of the patient and the family. These skills are then utilized to deal with volatile situations that often arise in the life of a patient of BPD. Regular feedback sessions, discussions and debates, and use of reflection (before, during and after) may augment deeper learning of conflict resolution, crisis prevention and management in the life of the patient.
- The use of mindfulness principles by helping the patient slow down and opt out of hurry may be initially difficult but eventually grounded can be of immense therapeutic value. Patient's ability to become aware of his or her switch from his 'being mode' to 'doing mode' can also help achieve reduced impulsivity and poor control of emotions.
- The behaviour activation principles derived from CBT to achieve goal oriented activities can bring in stability and achievement in the life of the patient. Use of behaviour therapy principles may lead to positive outcomes through behaviour modification and rehabilitation.
- Using principles of Cognitive Analytic Behaviour Therapy, particularly towards the conclusion of the treatment, through writing of formal letters and detailed input to patient and family can enhance impact of therapy and help prevent relapses.
- Patients of BPD harbour multiple cognitive distortions. The use of principles of CBT can help in setting up behavioural experiments to test the cognitive distortions and change them.
- Supportive and symptomatic treatment as well as treatment of co-morbid conditions including evidence-based treatment and short hospital admissions for behaviour modification, management, as well as treatment of overdoses, cuts, injuries, providing relief to family, and acute treatment with medications based on international guidelines is supported.
- Access and availability of peer support for mental health professionals committed to treatment of BPD patients may go a long way in the prevention of their burnout and negative counter transference. This provision is a crucial last principle in this list.

These points form the basis of the Rawalpindi interest group's manual for BPD. The group also aims to serve as a potent information care resource for medical professionals as well as the general community. The resource centre would also include evidence based management protocols to be used by therapists who might not be formally trained in managing patients with Borderline Personality Disorder. With the support of a healthy mix of national and international mental health professionals with special interest in BPD, this platform aims to develop consensus guidelines to diagnose and manage BPD in Pakistan. The group meets on a monthly basis to work in sub groups to draw well-researched, evidence-based, culture specific management guidelines. These guidelines will then take shape to publishing of a book along with a step-by-step manual for a mental health professional dealing with a patient of BPD.
This editorial is an attempt to invite critique and peer review on the subject.

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