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Editorial

Current healthcare challenges in treating the borderline personality disorder "epidemic

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Abstract

The recent increase in the number of patients accessing healthcare services with a diagnosis of borderline personality disorder continues to put unprecedented pressure on healthcare professionals. It is likely that considerable national health service resources will have to be allocated to these patients in the future.

Keywords: borderline personality disorder, healthcare leadership, psychiatry, healthcare professions

The recent increase in the number of patients presenting with a borderline personality disorder (BPD) in general adult psychiatry and primary care is creating pressure within the National Health Service (NHS)[1].Currently, BPD is perceived to be like an 'epidemic' entity, particularly in areas with a high incidence of socioeconomic deprivation. Similarly, there is a parallel increase in the human and medical resources needed to manage this disorder efficiently. In fact, the authors have found that BPD tends to be comorbid with factitious disorders and depression (Tripolar syndrome) with a tendency to overuse hospital and medical facilities, inclusive of Accident and Emergency (A&E) departments, family doctors and General Practitioner (GP) surgeries[2].

Consequently, patients with BPD require a constant and unlimited allocation of medical and psychiatric resources, together with targeted care plans. In fact, they might be prone to frequent self-referrals to A&E, seek hospital admissions and augment all their psychotropic medications in order to deal with their on-going crises not solvable in their homes. Also, the skills needed by healthcare personnel to reduce chronic self-harming and suicidal ideation in this vulnerable population are complex and need to be updated on an on-going basis also due to the tendency of these patients to raise allegations towards their healthcarers[3]. Nonetheless, the provision of treatment is often hindered by various healthcare system limitations, such as the lack of beds on medical and psychiatric units, forced reduction in the length of stay in a hospital and insufficient human resources. This scenario has mostly affected female patients with BPD who seek admission to psychiatric hospitals often for respite from chronic suicidal ideation[4].Moments of amplified suicidal ideas become evident when internal voices, perceived as auditory hallucinations commanding to self-harm or to commit suicide, become more intense[5].

As observed by the authors of the current editorial, increased suicidal ideation in persons with BPD also occurs during minor crises in life, when experiencing intensified flashbacks about past abuses, during minor losses, after significant conflicts with others and after the separation from influential people in their social network. Besides, admissions in psychiatric wards, very commonly, occur when there is an intensification of internal voices commanding BPD patients to take overdoses of the prescribed medication or to jump in front of a train, a car or off a pier to commit suicide. Police is often involved to stop these dramatic plans. At the same time, healthcare professionals are discouraged by the complex management of patients with BPD, which, in combination with their tendency to challenge or make unwarranted allegations against their health carers, results in feelings of sadness, rejection and alarm in the latter. Kanin reported that the reason to produce a false allegation is to create a defence or to get compassion[6]. Nonetheless, it is also likely that some healthcare professionals might have some preconceived ideas about people with Borderline Personality Disorder, which might reduce the depth of health carers' empathy towards these patients and lead to burnout after prolonged treatment of BPD in hospital or community. Attempts to treat and to reduce suicidal ideation and self-harm in this group of patients are often thwarted as they challenge medical decisions and endeavour to sabotage the proposed care plans. The strain on the doctor-patient relationship is determined by the underlying 'Mistrust/Abuse' scheme of patients with BPD who expect from others, and are thus sensitive to, signals of relational wound, treachery and abuse[7].

Consequently, a chronic feeling of inadequacy in patients with BPD translates itself in enduring dissatisfaction with any therapy and healthcare professionals. Hence, in the authors' experience, any attempt to establish a long-term therapeutic relationship with BPD patients might have limited outcomes. Frustration in healthcare professionals aiming to create an enduring therapeutic alliance with patients with BPD happens as these patients tend to interpersonal biases and to ascribe undesirable experiences to people (hence to healthcare professionals) as opposed to circumstances[8]. Therefore, social interactions with primary carers result in dissatisfaction of people with BPD about any medical or psychiatric plan is set

up for them. Consequently, community teams, general practitioners and hospital staff feel hopeless due to recurrent readmissions of people with BPD and the lack of definitive treatment for such pathology. Stress caused by difficulties encountered in ensuring that BPD patients comply with the therapy regularly places doctors and nurses at crisis point.

Once in the hospital, discharging patients with BPD can be difficult as they are frequently reluctant to return to the community, leading to recurrent readmissions within a short period. In fact, the period before discharge from a psychiatric hospital is complicated by mounting anxiety and distress in patients with BPD. The authors observed a regular escalation of self-harming behaviours and increased suicidal ideation in these patients just before discharge, possibly indicating their underlying anxiety in going back to the home environment. Many BPD patients suggest that they would rather stay in the hospital instead of returning to the community that is considered by them as unsafe or unstructured. Furthermore, as these patients have an intense vulnerability to social rejection, they rarely feel adequate during social interactions thus developing an enduring sense of solitude[9]. Therefore, any hospital discharge or a visit to the GP will be interpreted by them as disappointing and will lead patients with BPD to confirm their sense of rejection. As a reaction, the authors observed that BPD patients demand endless and unconditional attention from their primary carers. Attempts by patients with BPD to self-harm or commit suicide intensify over weekends or public holidays as their sense of solitude increases during these periods, especially when there is also a shortage of healthcare professionals available for immediate support.

The authors of the current editorial propose possible strategies of intervention both on the psychopharmacological and managerial side. The challenge is that patients with BPD often use overdoses of oral medication in a suicide attempt[10]. Hence, the authors recommend the use of long-lasting depot antipsychotic injections (e.g., Zuclopenthixol Decanoate) to stabilise their mood and reduce impulsivity, the risk of overdoses, pseudo-psychotic symptoms and command hallucinations leading to deliberate self-harm. The use of oral lithium to treat mood swings poses an ethical dilemma for doctors as it could be lethal when used as an overdose. Healthcare management is another way of intervention. One point of difficulty is the tendency of patients with BPD to split their teams and to create niches of protectors and opposers within staff with possible conflicts within the team that is treating them. In this case, inter-professional coordination, integrated care and constant information sharing are required[11]. Furthermore, several healthcare services treating patients with BPD are trying to find an integrated approach for their hospital and community treatment. The authors speculate that the increased number of admissions of patients with BPD is reducing the total capabilities of physical and mental wards to treat patients with other pathologies. Besides, the dramatic presentation of patients with BPD who tend to overuse the healthcare services poses ethical dilemmas in their management. This scenario has created discrepancies in health care policies about treatments and hospital (re)admissions of patients with BPD reaching an epidemic magnitude in many healthcare trusts. Hence, a new culture is required for the management and treatment of patients with BPD in the community.

Culture is defined as the character of an institution that affects employee gratification and organisational accomplishments[12].What is needed is a frank and constructive dialogue between healthcare managers, leaders and medical staff in the hospital and in the community. Furthermore, clear and regional guidelines should exist to improve the efficacy of care which is offered to BPD patients at home and to reduce the constant risks which patients pose to themselves, their sense of solitude and their tendency to seek hospital admission in order to solve chronic existential difficulties. A model of integrated care comes from Max Weber who differentiated between 'formal rationality', the endorsement by healthcare managers of the most efficient ways of achieving organisational goals (e.g., ensuring more hospital beds by quick discharges of 'bed blockers'), and 'substantive rationality', the expectation by healthcare professionals that values and morals should instead be based on tradition, compassion and dedication[13];pertinent to the care of BPD patients in our case. The collaboration of all those involved parties is also important to reduce the risk of 'silo management' where confined and regional policies do not embrace a wider perspective for the management of specific problems while responding only within the confines of the own guidelines and procedures[14].In these cases, integrated care in communities can halt self-harming and suicidal attempts of patients with BPD. The organigram sees inter-professional actions, targeted psychopharmacological policies and psychiatric crisis teams in A&E that can reduce the need to hospitalise patients with BPD at any ensuing crisis.

Competing Interests
None declared

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