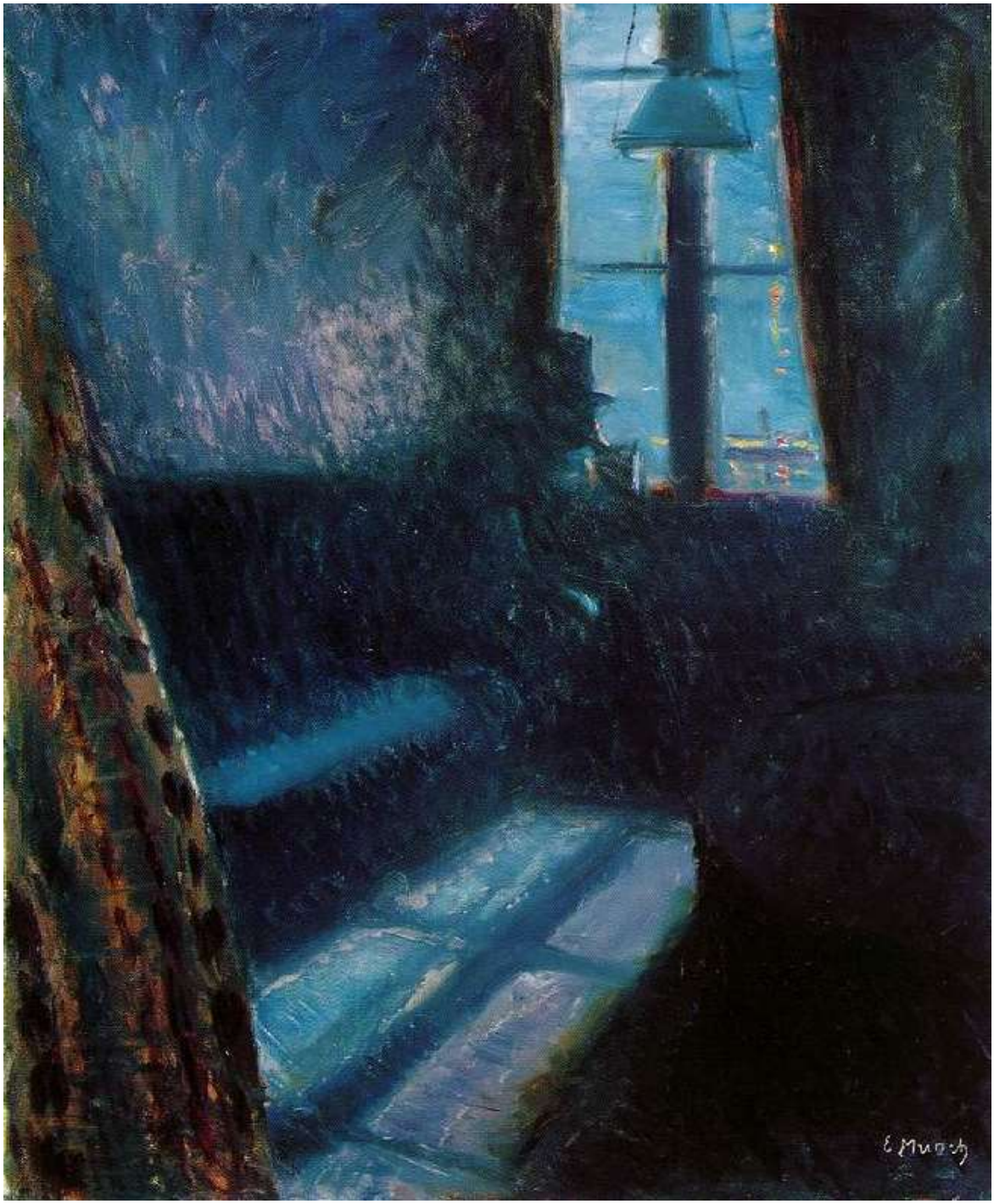
THE NORTHERN HOSPITAL

BORDERLINE PERSONALITY DISORDER



"Night in St Cloud", oil on canvas, 1890, Edvard Munch, National Gallery Oslo, Norway.

From hell, Mr Lusk, Sir

I send you half the Kidne I took from one women prasarved it for you, tother piece I fried and ate it was very nice. I may send you the bloody knif that took it out if you only wate a whil longer.

Signed, Catch me when you Can Mishter Lusk

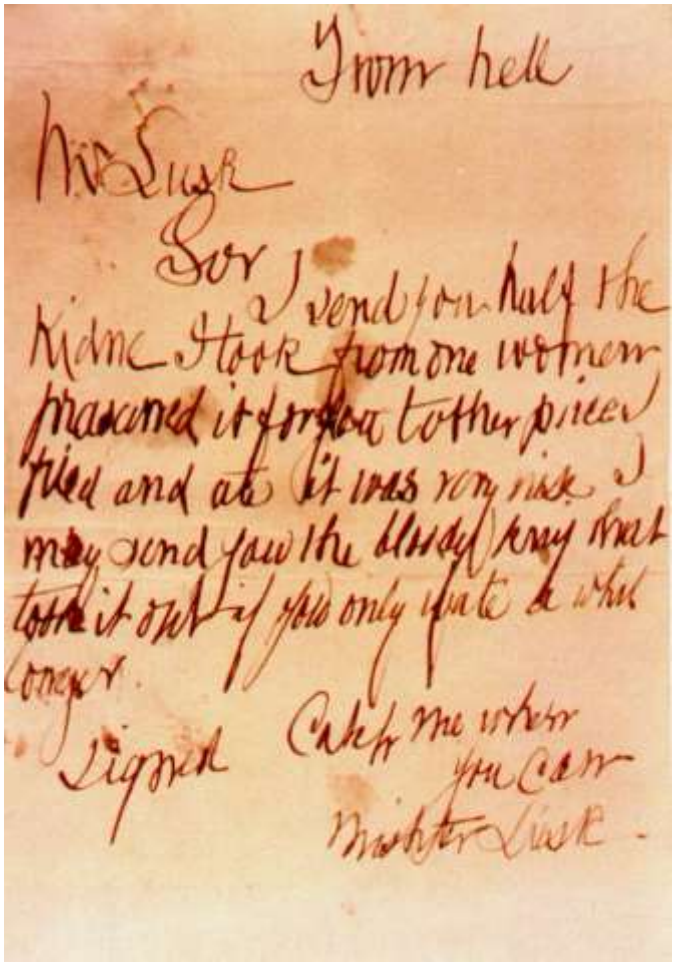
Between August and November 1888 a series of five horrifically brutal murders took place in the Whitechapel region of the city of London. All victims were street prostitutes, and all - except for one - Elizabeth Stride - were horribly mutilated. The manner in which they were killed and mutilated, strongly pointed to the act of a single person. The first murder, was that of Mary Ann Nicholls, and took place on 31 August. Annie Chapman was killed on 8 September, while Elizabeth Stride and Catherine Eddowes were both murdered on 30 September. Mary Jane Kelly was murdered on 9 November 1888. There were possibly a number of other murders as well, but the links with these additional killings was somewhat more tenuous. Then the murders ceased - just as inexpiably and as suddenly as they had began. Terror gripped all of London and the media dubbed the monstrous killer, "Jack the Ripper".

People refused to leave their homes after dark. Paranoia, terror and suspicion was rife. London was gripped in an all pervasive nightmare. Undercover police and citizen vigilante groups scoured the dark back streets and taverns of Whitechapel in a desperate effort to catch a monster from Hell. Despite a massive and unprecedented police and public effort to catch the killer, his (or her) identity was never discovered and over the ensuing century and beyond the story of Jack the Ripper has held a macabre fascination in the collective psyche of the general public in England, and indeed the world over. The killings created a media sensation at the time both in England and throughout the world. There had been serial killers before, and of course there has been since, but the case of Jack the Ripper was unique as being the first that had had the story told by a modern media with rapid worldwide dissemination - but also because of the shear sickening brutally in which the random murders were carried out - unequalled in the past - and not often repeated in since.

Oceans of ink have been spilt over speculation as to the identity of the killer. Everyone had a theory as to the identity of the shadowy Whitechapel horror. The case was passionately discussed throughout England, and especially so in the seedy taverns of Whitechapel. Strangers were viewed with deep suspicion and fear. Suggestions ranged from the mundane to the truly sensational. Because of the savage mutilation in each case, a favourite suggestion was that the killings were perpetrated by a butcher - or even a medical doctor because of the way in which some of the victims had had their kidneys removed. Many cranks "confessed" - but the most chillingly authentic claim was seen in the so-called "Letter from Hell" - which seemed to have firsthand knowledge of the murders - knowledge that had not been made known to the general public. It was sent to George Lusk, postmarked 15 October 1888. Lusk was head of the Whitechapel Vigilance Committee, a group of local volunteers who patrolled the streets of London's Whitechapel District during the period of the murders. Its writer had knowledge that the kidneys of some of the victims had been removed which lent great authenticity to the letter.

Sickeningly it also claimed that these had been eaten - sporning the modern serial killer fiction story of Hannibal Lecter. Of all the claims - it is the "Letter from Hell" which is considered the most likely to have come from the real killer. Its prose appeared to be from a somewhat illiterate individual, possibly ruling out a medical doctor - but counter claims suggest that a clever individual could simply use the poor English to hide his (or her) real identity. Amoung the more sensational theories included one that linked the murders to Queen Victoria's grandson, Prince Albert Victor, also known as the Duke of Clarence, a theme explored in the 2001 Twentieth Century Fox Motion film "From Hell", starring Johnny Depp and Heather Graham. After November 1888, the murders, suddenly ceased. Whether the perpetrator, was murdered, imprisoned or died remains, like the identity of the killer, completely unknown to this day.

It is impossible to imagine the inner psyche or motivation or the lack of normal human empathy of a person capable of random killing in the manner of the individual known as Jack the Ripper. In the modern age we now continue strive to understand the pathological disturbances that can destroy a human mind and soul. If we can identify individuals at risk at an early time and apply effective therapeutic interventions and treatments we may perhaps hope to avert some of the very worst manifestations of these disturbances.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The "From Hell", letter, thought the most likely communication from the real Jack the Ripper.

BORDERLINE PERSONALITY DISORDER

Introduction

The NH&MRC has recently published a set of 63 recommendations for the assessment and management of patients with Borderline Personality Disorder (BPD) [1]

The following is a general summary based largely on these recommendations with respect to issues relevant to the Emergency Department setting.

Borderline personality disorders (BPD) are frequent presenters to Emergency Departments present a difficult challenge to Emergency Departments.

Health professionals at all levels of the healthcare system and within each type of service setting should acknowledge that BPD treatment is a legitimate use of healthcare services. [1]

The diagnosis of BPD is not one made in the Emergency Department, but patients with this condition frequently present because of its consequences, including:

- Medical condition.
- Psychiatric Condition
- Acute Social Crisis
- Drug affected
- Self harm/ trauma/ overdose

On presentation it is important to establish a safe environment for both staff and patient.

Pathology

Psychiatrists identify a number of distinct personality disorders including anti-social, borderline, schizotypal and others.

Borderline personality disorder (BPD) is a common mental illness characterised by poor control of emotions and impulses, unstable interpersonal relationships and unstable self-image.

Symptoms of BPD typically emerge during adolescence and early adulthood.

People with BPD experience significant suffering and distress due to difficulties in relating to other people and the world around them, disruption to family and work life, and social problems.

The diagnosis of BPD is associated with considerable social stigma.

Complications of BPD:

BPD is associated with:

- Severe and persistent impairment of psychosocial function
- High risk for self-harm (including drug and alcohol abuse) and suicide
- A poor prognosis for any co-existing mental health illnesses.
- Heavy use of healthcare resources.

The prognosis for people with generally BPD is good over the medium to long term with a high proportion of people with BPD recover significantly and no longer meet diagnostic criteria for BPD.

Among those who experience remission, only a minority relapse.

Longitudinal studies with follow-up of 10-16 years have reported that almost all people with BPD will eventually achieve symptomatic recovery, but may still experience some impaired psychosocial functioning.

Risk factors for BPD:

Risk factors for the development of BPD include:

1. Genetic factors
2. Socioeconomic deprivation
    - Including family welfare support recipient status and single-parent family status
3. Trauma or stressful life events:
    - Including maladaptive school experiences,
4. Poor or inconsistent parenting:
    - Including childhood physical abuse, sexual abuse or neglect
5. Co-occurring psychiatric conditions.

A number of precursor signs and symptoms during adolescence have been associated with subsequent onset of BPD including:

- Substance use disorders during adolescence, particularly alcohol use disorders, specifically predict young adult BPD.

- Disruptive behaviour disorders (including conduct disorder, oppositional defiant disorder, and attention deficit hyperactivity disorder) in childhood or adolescence predict personality disorders, including BPD, in young adulthood.

- Depression in childhood or adolescence predicts personality disorders, including BPD, in young adulthood.

- Repetitive deliberate self-harm in children may be a predictor of BPD.

Diagnostic Criteria

BPD is usually diagnosed using American Psychiatric Association Diagnostic and statistical manual of mental disorders 4th edition – text revision (DSM-IV-TR) criteria.

World Health Organization International statistical classification of diseases and related health problems 10th Revision (ICD-10)181 also includes diagnostic criteria for unstable personality disorder, borderline type

DSM-IV-TR General diagnostic criteria for a Personality Disorder

The **General** diagnostic criteria for a Personality Disorder include:

A. An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture. This pattern is manifested in two (or more) of the following areas:

   (1) Cognition (i.e., ways of perceiving and interpreting self, other people, and events)

   (2) Affectivity (i.e., the range, intensity, lability, and appropriateness of emotional response)

   (3) Interpersonal functioning

   (4) Impulse control

B. The enduring pattern is inflexible and pervasive across a broad range of personal and social situations.

C. The enduring pattern leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The pattern is stable and of long duration and its onset can be traced back at least to adolescence or early adulthood.

E. The enduring pattern is not better accounted for as a manifestation or consequence of another mental disorder.

F. The enduring pattern is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., head trauma).

DSM-IV-TR diagnostic criteria for BPD: [2]

The specific Diagnostic criteria for a **Borderline Personality Disorder** are: [2]

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: these do not include suicidal or self-mutilating behavior covered in Criterion 5.

2. A pattern of unstable and intense interpersonal relationships characterized 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 behavior covered in Criterion 5.

5. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior.

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.

ICD-10 diagnostic criteria for emotionally unstable personality disorder, borderline type [3]

Emotionally unstable personality disorder is characterised by:

- A definite tendency to act impulsively and without consideration of the consequence
- Unpredictable and capricious mood
- Liability to outbursts of emotion and an incapacity to control the behavioural explosions
- Tendency to quarrelsome behaviour and to conflicts with others, especially when impulsive acts are thwarted or censored.

Two types may be distinguished: impulsive type and borderline type.

The borderline type is characterised by disturbances in self-image, aims, and internal preferences, by chronic feelings of emptiness, by intense and unstable interpersonal relationships, and by a tendency to self-destructive behaviour, including suicidal gestures and suicide attempts.

Assessment

BPD is not a diagnosis made in the Emergency Department.

Patients will usually present in some acute crisis relating secondary issues such as:

- Social Crisis
- Trauma, (as a result of assault as well as accident)
- Acute psychiatric disturbance
- Drug or alcohol intoxication

Patients will often present in a state of high agitation, and it is important that a safe environment is established before assessing them. This may require the involvement of security and/ or police.

For patients with known BDP, a frequent presenter plan may be in place and so assessment and management can be guided by this.

Patients who do not have a formal diagnosis of BPD, suspicion is raised by the following and health professionals should consider referral for formal assessment for BPD (and/or or referral for psychiatric assessment) for a person (> 12 years of age):

- Frequent suicidal or self-harming behaviour

- Marked emotional instability
- Multiple co-occurring psychiatric conditions
- Non-response to established treatments for current psychiatric symptoms
- A high level of functional impairment.

The diagnostic criteria for BPD should **not** generally be applied to prepubescent children.

There are validated screening tools that can assist in making a diagnosis of BPD, that can be applied by suitably trained Health Practitioners.

Of particular relevance to the ED is an assessment of suicide risk in patients with BPD

Factors associated with increased suicide risk, compared with previous level of risk, include:

- Changes in usual pattern or type of self-harm.
- Significant change in mental state (e.g. sustained and severe depressed mood, worsening of a major depressive episode, severe and prolonged dissociation, emergence of psychotic states)
- Worsening in substance use disorder
- Presentation to health services in a highly regressed, uncommunicative state
- Recent discharge following admission to a psychiatric facility (within the past few weeks)
- Recent discharge from psychiatric treatment due to violation of a treatment contract
- Recent adverse life events (e.g. breakdown or loss of an important relationship, legal problems, employment problems or financial problems).

Other factors associated with increased risk of suicide include:

- Co-occurring mental illness
- Antisocial or impulsive personality traits or a co-occurring antisocial personality disorder
- History of childhood sexual abuse, especially incest and prolonged abuse

- Number and lethality of previous suicide attempts
- Experiences of loss in childhood.

Management

On presentation it is important to establish a safe environment for both staff and patient.

For very agitated patients physical / chemical restraint may initially be required.

See separate guidelines for these.

Interventions for BPD and co-occurring mental illness should be integrated, and coordinated as far as possible.

Where more than one treatment option or service setting is suitable for an individual's clinical needs, health professionals should explain the options and support the person to choose.

With regard to the BPD itself the following points are recommended:

Empathic approach:

Helpful ways of interacting with the person who has BPD, include:

- Showing empathy and a non-judgemental attitude
- Encouraging the person to be independent by allowing and supporting them to make their own decisions, but intervening for their safety when necessary
- Listening to the person with BPD when they express their problems and worries.
- People with BPD may be demanding and difficult, expecting to be seen immediately or without an appointment and so some boundaries may need to be set.

Crisis Management Plans:

- For people with BPD who **repeatedly present to emergency departments**, treatment providers should establish a **crisis management plan** that explicitly outlines the person's assessment and management in the emergency department, in addition to an overarching management plan.
- These plans should be developed in active liaison with the emergency department.

Family or care giver involvement:

- Health professionals should include families, partners and carers of people with BPD when developing crisis plans, if possible and with the person's consent.

- Health professionals should provide families, partners and carers of people with BPD with information about dealing with suicide attempts or self-harm behaviour.

Psychological Therapies:

- Health professionals should consider referring people with severe and/or enduring BPD to a **suitable specialised BPD service** (where available) for assessment and ongoing care, if appropriate.

- People with BPD should be provided with structured psychological therapies that are specifically designed for BPD, and conducted by one or more adequately trained and supervised health professionals.

- Adolescents with BPD should be referred to structured psychological therapies that are specifically designed for this age group. Where unavailable they should be referred to youth mental health services.

- Where more than one structured psychological therapy is available to a patient, a choice should be offered to the patient.

Medications:

- In extreme behavioural, drug affected or psychiatric distances disturbances, emergency chemical restraint may be required.

  See also Chemical Restraint Guidelines.

- Medicines should not be used as primary long term therapy for BPD, because they have only modest and inconsistent effects, and do not change the nature and course of the disorder.

- The use of medicines can be considered in **acute crisis situations** where psychological approaches are not sufficient.

  The **time-limited** use of these medicines should be considered as an adjunct to psychological therapy, to manage specific acute symptoms.

- **The prescribing of medicines that may be lethal when taken in overdose is best avoided where possible, because of high suicide risk with prescribed medicines among people with BPD.**

- **Caution should be used if prescribing medicines associated with substance dependence.**

- Avoid polypharmacy, as far as possible

- Establish likely risks of prescribing, including interactions with alcohol and other substances.

- If medicines have been prescribed to manage an acute crisis, they should be withdrawn once the crisis is resolved.

Coordinating Case Manager:

- If more than one service is involved in an individual's care, services should agree on one provider as the person's main contact (main clinician), who is responsible for coordinating care across services.

- All health professionals treating people with BPD should make sure they know who the person's main clinician is.

Disposition Issues

With regard to issues of disposition, the following points are recommended:

Community based treatment:

- The majority of a person's treatment for BPD should be provided by **community-based** mental health services (public or private), and not by Emergency Departments.

- Clinicians treating people with BPD should follow a stepped-care approach in which an individual's usual care is based on the *least intensive treatment (such as general practice care and regular contact with a community mental health service),* and referral to more intensive treatment (such as crisis intervention, a specialised BPD service, or specialised BPD programs) is provided when indicated.

- Health professionals within each type of service should set up links with other services to facilitate referral and collaboration.

Families of carers of patients with BDP:

- Health professionals should also refer families, partners and carers of people with BPD to support services and/or psychoeducation programs on BPD, where available.

- Health professionals can support families, partners and carers by referring or directing them to:

- ♥ General family counselling and psychoeducation with a focus on BPD
- ♥ Structured family programs specific to BPD
- ♥ Peer support programs such as carer-led programs that educate families/carers on BPD
- ♥ Respite services.

Substance abuse:

- Treatment should focus on managing substance abuse before that of BPD so that treatment of BPD can continue.

Hospital Admission:

- Acute inpatient admission to provide structured crisis intervention could be considered for the treatment of people who are suicidal or have significant co-occurring mental health conditions.
- Inpatient care should be reserved for short-term crisis intervention for people at high risk of suicide or medically serious self-harm. Where used, inpatient care should be:
  - ♥ Brief (except for specialised structured residential services that provide intensive interventions)
  - ♥ Directed towards specific, pre-identified goals.
- Long-term inpatient care for people with BPD should generally be avoided, except in the context of specialised BPD services.
- When considering inpatient care for a person with BPD, health professionals should involve the person (and family or carers, if possible) in the decision, and ensure the decision is based on an explicit, joint understanding of the potential benefits and likely harm that may result from admission, and agree on the length and purpose of the admission in advance.

Children:

Health professionals assessing a person with BPD (particularly during a crisis) should determine whether the person has dependent children and ensure that they are properly cared for (e.g. refer to a social worker).

Health professionals caring for parents with BPD should consider the needs of children and arrange assessment of their mental health and welfare needs if necessary.

If a mother with BPD requires hospital admission, separation from her infant should be avoided if possible.

Health professionals involved in the assessment of parenting capacity should advise authorities that a parent's BPD *alone* is not sufficient reason for removing a child from the parent's care.

People with BPD who have infants or young children should be provided with interventions designed to support parenting skills and attachment relationships.

Where children are carers of an adult with BPD, specific support should be provided, including:

- Education about the parent's mental illness
- Strategies for management of adult's emotional and psychological states
- Strategies for helping them with peer relationships and social functioning
- Psychological and emotional support
- Referral to services for young people who are carers
- Respite services.

"A Tavern in Whitechapel", oil on canvas, c. 1869, Gustave Dore.

References

1. NH&MRC Clinical Practice Guideline for the Management of Borderline Personality Disorder, 2013

2. DSM-IV-TR: Diagnostic and Statistical Manual of Mental Disorders (DSM) 4th ed Text Revision, 2000.

3. World Health Organization International statistical classification of diseases and related health problems 10th Revision (ICD-10) diagnostic criteria for the borderline type of unstable personality disorder.

Dr J. Hayes
2 April 2013.