Frequently Asked Questions

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What medications can I prescribe for BPD?

- Unfortunately there are no medications specifically developed for BPD.
- Omega-3 Fatty acids, lamotrigine, topiramate, aripiprazole or quetiapine may help reduce the intensity of some symptoms for some patients. However the evidence for their utility is limited.
- About 25% of patients with BPD reportedly attempt suicide with prescribed medications, suggesting that caution be used when prescribing.

(See Chapter 5)

When should I send a person with BPD to an Emergency Department?

The following describe some situations when sending a person with BPD to the emergency department is indicated:

- The risk formulation is indicative of acute/imminent suicide risk.
- If there is a change in the pattern of self-harming behaviour suggestive of increased potential lethality.
- Co-occurring disorders require urgent treatment (e.g. severe and persistent substance use, acute psychosis).

(See Chapter 6)

When should I send a person with BPD to a public mental health service for hospitalisation?

- When the patient is at acute risk for suicide or high lethality self-injury.
- For management of imminent suicide risk.
- If a co-occurring psychiatric disorder (e.g. severe depression, psychosis, SUD) requires urgent assessment, treatment and admission.
- In situations of escalating self-harm and repeated presentations to the ED, a brief admission may assist assessment, defuse crises and break the cycle.

(See Chapters 3, 5 and 6)

Do people with BPD recover?

- People with BPD do recover, with 43% of patients achieving recovery eight years after hospital admission in a large prospective study.
- 60% of the same cohort of patients achieved recovery by 16 years.
- 88% of these patients achieved remission, defined as no longer meeting diagnostic criteria for BPD, by eight years and 99% achieved remission by 16 years.
- All of these patients received non-specialist community treatment for BPD during the follow-up period.

(See Chapter 1)

Given the lack of adequate access to evidence-based treatments, where can I refer a person who has severe BPD?

- Spectrum, the Personality Disorder Service for Victoria, was established to treat the most severe and complex BPD cases in this state.
- Assessment and possible treatment at Spectrum can be arranged by contacting Spectrum *(see Resources).*
- Some Area Mental Health Services (AMHSs) in Victoria offer one or more evidence-based treatments for people with BPD e.g. DBT, MBT.
- Private psychiatric facilities may offer DBT and other programs for BPD.
- Psychiatrists in private practice who are willing to treat someone with severe BPD must be contacted directly.

(See Resources section)

What is the relationship between BPD and chronic pain?

- Chronic pain is a frequent symptom in people with BPD.
- 30% of patients with chronic pain syndromes suffer from BPD.
- Physical pain in these patients can function as a defense against unbearable emotional pain.
- Chronic pain in BPD can also relate to co-occurring physical disorders, e.g. osteoarthritis secondary to obesity.

(See Chapter 2)

What is the relationship between BPD and PCOS?

- Women with BPD suffer higher than expected levels of PCOS, although precise levels of co-occurrence are not yet known.
- A psycho-neuro-endocrinological mechanism probably underpins the elevated prevalence of PCOS in BPD.
- Some of the mood symptoms of BPD may be exaggerated by the hormonal imbalance of PCOS.

(See Chapter 2)

How can I confirm the diagnosis of BPD?

- Refer patient to a psychiatrist who has an interest in BPD *(see Resources section for details).*
- Refer to DSM-5 criteria for BPD in the Appendix. If your patient meets more than five of these, a diagnosis of BPD can be made.
- Refer patient to the Assessment Clinic at Spectrum for a diagnostic opinion *(see Resources section for details).*

(See Chapter 1 and Resources)

Are people with BPD generally manipulative in their interactions with clinicians?

- People with BPD can behave in ways that appear manipulative.
- Such behaviours occur because they were effective for getting their needs met during childhood.
- They happen because the person with BPD knows no other way of getting their needs met.

(See Chapters 1 and 2)

How can I distinguish BPD from a Bipolar Disorder?

- The mood swings in BPD are reactive, usually in response to interpersonal events.
- Mood swings in BPD last only minutes, hours, rarely days, and shift in relation to environmental events, most of which are interpersonal in nature.
- Mood swings in Bipolar Disorder are longer lasting and much less reactive to environmental events.
- Euthymic periods occur between episodes of depression or hypomania in Bipolar Disorder.

(See Chapter 2)

How can I distinguish BPD from a Schizophrenia/ Schizoaffective disorder?

- Psychotic symptoms in BPD are commonly transient and triggered by stress.
- Persistent delusions, hallucinations, negative symptoms and bizarre behaviours are uncommon in BPD.
- Although people with BPD commonly experience mood fluctuations, they don't have the full syndrome of mania, hypomania or Major Depressive Episodes as part of the BPD psychopathology.

(See Chapter 2)

How can I identify acute suicide risk in a person with BPD who has constant suicidal feelings?

- Look for a change in the pattern (frequency, method, severity) of self-injury or suicidal behaviours as this can indicate acute suicide risk.
- People with BPD may have experienced suicidal thoughts for the best part of their lives. Suicidal thoughts alone may not always indicate that they are acutely suicidal.
- People with BPD may feel suicidal in order to survive. It is a common coping mechanism.

(See Chapter 6)

What do I do when a person with BPD gets angry with my reception staff?

- Remain calm and non-retaliatory when you see the patient.
- Ask them to tell you what made them angry.
- When appropriate, validate the distress, apologise and explain the reason for the event that triggered their angry response.
- Let them know that while you want to hear any complaints they may have about reception staff, these should be addressed to you, not to staff.
- When necessary, explain that the practice policy is to ask patients to leave the building if they are unable to control angry outbursts, and return when they are calm.

(See Chapter 2)

What should I do if a person with BPD has cut themself and is bleeding in the bathroom attached to the clinic?

- After attending to the medical needs of the person, ask the person what made them self-injure at the clinic.
- Empathise and validate the person's concerns.
- Focus on the person's emotions and mind not just the behaviours.
- Don't assume that the self-injury is a manipulative or suicidal behaviour.

(See Chapters 1 and 2)

What should I do when the patient is shouting at me in an abusive manner?

- Try to remain calm and refrain from retaliation.
- Ask them to stop shouting because you are unable to think when shouted at.
- Say that you want to understand what has upset them, and suggest they try to tell you about it.
- If they continue to shout, suggest they take 'time out' to calm down, then you will see them again.

(See Chapter 2)