

Borderline Personality Disorder and Diabetes: A Potentially Ominous Mix

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No psychological characteristic arouses as much interest and frustration as borderline personality disorder (BPD). While complex and richly symptomatic on one hand, it is, on the other hand, difficult to treat effectively with any current techniques.¹ People with BPD bring with them the promise of unstable personal and therapeutic relationships, growing demands for service and support, and, in the end, the strong likelihood of failure to achieve any defined goals.²⁻⁴

When seen in the health care setting, patients with BPD are often a challenge to provider organizations.^{5,6} They arouse intense emotional reactions from medical staff and others. They can pit care providers against each other. They often occupy substantial amounts of time and resources in frequently futile attempts to help them solve either their medical conditions or their recurrent dissatisfactions with the care process. And usually, but not always, they end their stormy course with a health care organization with a negative termination of the therapeutic relationship, complete with a vigorous litany of the many failings of the health care group. They are more apt to litigate against health care providers than are other patients.^{7,8}

Although there is only a modicum of specific data on the care of diabetic patients with BPD, these issues may apply to the treatment of those patients, as well as to all other BPD patients. Having BPD tendencies may be associated with poor glycemic control and other stresses in the therapeutic process.⁹⁻¹¹ It may also influence how patients respond to specific clinical situations, such as insulin-induced hypoglycemia.¹²

For provider organizations, BPD represents a potentially serious problem of financial and legal risk management. Patients with BPD usually occupy a disproportionate amount of staff time and resources. Their demands for service and support vastly exceed those of the average patient. The efforts to resolve their frequent and multiple customer service complaints may consume an extraordinary amount of administrative time and effort. And the likely failure of the provider group to achieve clinical improvement in these cases, coupled with the likelihood that the patient will deny any self-responsibility for these failures, makes these cases frequent risk management issues.

Because the care process in diabetes involves so much patient self-responsibility, these issues magnify in patients who have both BPD and diabetes. Because these cases entail so much financial and risk management, a consideration of this clinical combination is relevant from an organizational and business perspective.

Clinical Description of BPD

Most patients with BPD are women, but the condition also occurs in men. BPD patients exhibit three coping characteristics and four symptom complexes that affect their clinical course in the management of diabetes and that may be used as clinical markers to identify these individuals (Table 1). The coping characteristics include splitting behavior, sabotaging behavior, and victim-rescuer relationships. Underlying these specific behaviors is the general tendency to make specific situations more emotional and more explosive than is warranted.

Splitting behavior

This coping process involves pitting one individual against another. The specific issue that apparently causes this behavior is actually not relevant to BPD patients, nor is the position each health professional assumes in regard to the specific issue. What is important for this individual is that a problem is identified around which the individual can set various health professionals in opposition to each other.

Case in point. A 45-year-old woman with type 2 diabetes is admitted to the hospital, and a fasting lipid profile is ordered. At 7:00 A.M. the next morning, a 26-year-old phlebotomist enters the patient's room to obtain the venous blood specimen for this test. After one futile attempt at venipuncture (made futile because the patient wrenched her arm away from the technician during the process), the patient demanded that the venipuncturist leave her room and requested that the head nurse for that floor see her. When the head nurse arrived, the patient complained about how inadequate her care was because an

Table 1. Coping Characteristics and Symptom Complexes in BPD

Coping Characteristics

- Splitting behavior
- Sabotaging behavior
- Victim-rescuer relationships

Symptom Complexes

- Impulsive and self-destructive behavior
- Rapid mood swings with anxiety and depression
- Feelings of boredom and isolation
- Intense and unstable personal relationships

inexperienced venipuncturist was sent to draw her blood. The head nurse then called the senior phlebotomist, who came to see the patient.

The patient induced the senior phlebotomist to admit that her younger associate was inexperienced. The patient separately got the head nurse for the floor to admit that it was unprofessional for the senior phlebotomist to comment negatively about her junior associate. In the end, the patient never allowed the blood sample to be obtained. When asked by the attending physician why the blood was not sampled, the patient responded that there seemed to be discord among the staff, and they failed to remember to draw her blood.

Sabotaging behavior

This behavior involves a strategy on the part of the patient to devise apparently reasonable explanations about why therapeutic recommendations were not followed. However, these explanations usually have only a shred of reason and, on reflection, simply cover intentional manipulation on the part of the patient to make sure that the recommended treatments were not followed.

Case in point. A 32-year-old woman with type 2 diabetes comes to the health care office in early December for evaluation and treatment of her condition. She is advised to obtain a blood glucose monitoring device and to measure capillary glucose levels on a regular basis. She returns to the physician's office 4 months later accompanied by her husband. She informs the physician that she was never able to obtain a glucose monitoring device but asserts that this failure was her husband's fault. "I asked him to go get me a meter," she claims, "But he refused." The physician asks when she made the request of her husband. "Oh, only once since her last visit," her husband responds. "During halftime of the Super Bowl."

Victim-rescuer relationships

This behavioral pattern involves the establishment of a relationship in which the person with BPD plays the role of the

victim of some adverse behavior inflicted by someone else, and the health professional becomes the rescuer. Alternately, the pattern of relating to the health professional may involve situations in which the BPD patient may offer to "rescue" the health professional from some supposed problem *if* the health professional adequately rescues the patient from the problems inflicted on the patient by others. Usually, the patient asserts that his or her medical conditions have been poorly served by previous medical providers and that the current health professional will be one who will solve her clinical problems. Quite often, the current provider will fail to rescue the patient adequately from these medical problems, and the patient will then become the victim of the present health provider.

Case in point. A 54-year-old man with impaired glucose tolerance and hyperlipidemia comes in for treatment. He asserts that his two previous primary care providers and his previous endocrinologist were all inadequate care providers. Their shortcomings were evident to him on the basis of their knowledge of his conditions as well as the service their offices provided. He tells the current physician that he knows that he will be the "right" physician for him.

The patient has an initial evaluation and laboratory testing. He is given a follow-up appointment for a few weeks later. One week before his scheduled follow-up, he calls the office and demands that the physician discuss his laboratory work over the phone. He claims that the service he was given by the office staff when he presented for his laboratory work was too slow and inept and that he is "too busy to sit and wait through that again." When he is informed that the physician will not discuss over the phone laboratory results that are not critically abnormal, he becomes enraged and demands that he be given a copy of his medical records immediately.

Symptomatology for this disorder tends to cluster around four symptom complexes. These patients have impul-

sive and self-damaging behavior. They have rapid mood swings, with a tendency to experience anxiety and depression. They have chronic feelings of boredom and social isolation. And, they have intense and unstable personal relationships, which they devalue and manipulate frequently.

Health professionals may get drawn into relationship issues of these patients before they realize what the quality of the relationship truly will be. Patients can appear normal on first contact. However, over time, health professionals may begin to worry about why these relationships appear to be so stressful and demanding. Eventually, health professionals may realize that there are patterns of coping in such patients that are truly worrisome. However, by then health professionals often have been drawn into the relationship issues before realizing what is occurring.

Clinical Challenges of Diabetic Patients With BPD

Patients with BPD have a higher risk of other psychiatric comorbidities that can profoundly affect the success of diabetes care, and, often, these problems are not immediately evident.¹³ Therefore, diabetes care providers should consider whether such comorbidities may be present in diabetic patients with BPD tendencies. These comorbidities include drug addition, eating disorders, and suicide potential. There may also be a history of childhood sexual abuse, which may be a causative factor in the etiology of the BPD characteristics.¹⁴

Improving Outcomes and Reducing Service Issues

While no strategy is likely to make the experience of caring for BPD patients as successful and positive as caring for other patients, some approaches may help. The first and perhaps most important approach is to develop simple guidelines to help office staff and health care providers recognize patients who may have BPD characteristics. This is especially important for specialty dia-

betes practices. BPD patients are often candidates for referral from primary care providers or may seek specialty care on their own because of their high risk of failure in achieving clinical goals for diabetes in the primary care setting. Characteristics that may help to identify patients with BPD are shown in Table 2.

A second set of strategies involves developing a system to remind all staff about which patients have been identified as having BPD characteristics and the risks involved in dealing with these individuals versus most other patients. In our practice, we place a small colored sticker in the lower right-hand corner of the medical chart. The purpose of this system is not to negatively identify these patients; rather, it alerts staff that specific techniques in communication may be required to serve these customers.

A third helpful approach is to develop specific techniques to reduce the stresses that may occur in serving BPD patients. We try to limit the number of staff who interact with these patients at any one time to reduce the possibility that complex communication will induce the patients to use vagaries in communication (splitting behavior). We also give these patients only a few, simple tasks or suggestions at each visit. Finally, we encourage all staff to carefully document all interactions in detail in the charts of patients with BPD characteristics.

Table 2. Identifying Characteristics of BPD Patients in Diabetes Outpatient Settings

- Demand for emergency services for clinical situations that do not appear to be urgent problems
- Repeated dissatisfactions with details of service over issues that are minor
- Claims that the current health care group is far superior to numerous "inadequate" groups seen in the past
- Failure to carry out simple clinical instructions for odd reasons
- Escalating tensions with multiple members of the clinical staff

Managing Patient Termination

As this article suggests, many BPD patients may become dissatisfied with their care and terminate the therapeutic relationship. Often, this termination is negative, and the patient vents to the provider organization about a litany of "failings." These patients may press their dissatisfactions to relevant medical associations or state boards of medicine.

We suggest that any medical chart of a BPD patient be given to the risk manager or office manager of the provider organization at the first suggestion that the patient may be or is terminating the therapeutic relationship. The chart should be reviewed for the completeness and excellence of documentation. Behaviors or comments made by the patient regarding issues in service should be noted in detail. Negative, pejorative, or uncomplimentary descriptions of the patient should be avoided. The documentation should be totally objective.

Demands by these patients that their medical records be given to them on a "stat" or immediate basis should *not* be honored. State medical practice codes allow providers a "reasonable" period of time before they must provide patients with their medical records. In the case of BPD patients, this period should *always* be used to make sure the chart is as representative of the events involved as possible.

Hostile or negative attitudes toward these patients should also be avoided. The more fuel for emotional or inflammatory behavior the patient is provided by the medical office staff, the longer that patient will focus on the "issues" he or she experienced with that provider organization. It is best to allow these patients a graceful exit, if possible, so that they may move on to focus on other questions in their life.

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