Working with people with a diagnosis of Borderline Personality Disorder (BPD)

A practical resource for mental health practitioners

Who is this resource for?

The following resource is designed for mental health practitioners working in rural or regional NSW who have not completed specialty training in working with people with Borderline Personality Disorder (BPD), but are treatment providers for individuals with a diagnosis of BPD.

What does this resource include?

This is an introduction to working with individuals with a diagnosis of BPD and is not exhaustive nor designed as a treatment manual. We encourage all practitioners who are working with individuals with a diagnosis of BPD to seek specialised training in evidence-based treatments and engage in supervision.

I have a client with a BPD diagnosis, how can that present itself?

Individuals with a diagnosis of Borderline Personality Disorder (BPD) may experience difficulties in their relationships with themselves and others. This may include challenges such as poor self-concept, difficulties understanding who they are, low self-regard, challenges with knowing how to regulate their emotions, and high emotional states that change quickly. They may have difficulty in relationships such as challenges communicating, maintaining healthy boundaries and struggling to feel safe and secure with connections. This can lead to behaviours that might be considered impulsive, such as reactive decision making, engaging in non-suicidal self-injury, and thoughts and acts centred around ending their life.

There are two predominant diagnostic classifications for a diagnosis of BPD – the Diagnostic and Statistical Manual 5th Edition (DSM-5; see below) and the International Classification of Diseases 11th revision (ICD-11). You can find a good explanation of BPD here and an explanation of the symptoms here.

DSM-5 symptoms of BPD

"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:"

- Efforts to avoid real or perceived abandonment
- Unstable and intense relationships
- Unstable self-image and sense of self
- Impulsivity that is potentially self-damaging
- Suicidal behaviour or self-injury
- Marked reactivity of mood and emotion dysregulation
- Chronic feelings of emptiness
- Intense feelings of anger
- Stress-related paranoia or dissociation

(DSM-5, American Psychiatric Association, 2013)

Providing a diagnosis of Borderline Personality Disorder

Diagnosis of BPD should be provided by an appropriately qualified and experienced mental health professional and in collaboration with the person receiving the diagnosis.

Research and feedback from lived-experience experts has shown the importance of providing an openly communicated diagnosis of BPD. Click here for a guide on providing a diagnosis.

Make sure to offer a client access to further education, resources and have an open discussion about any questions they have.

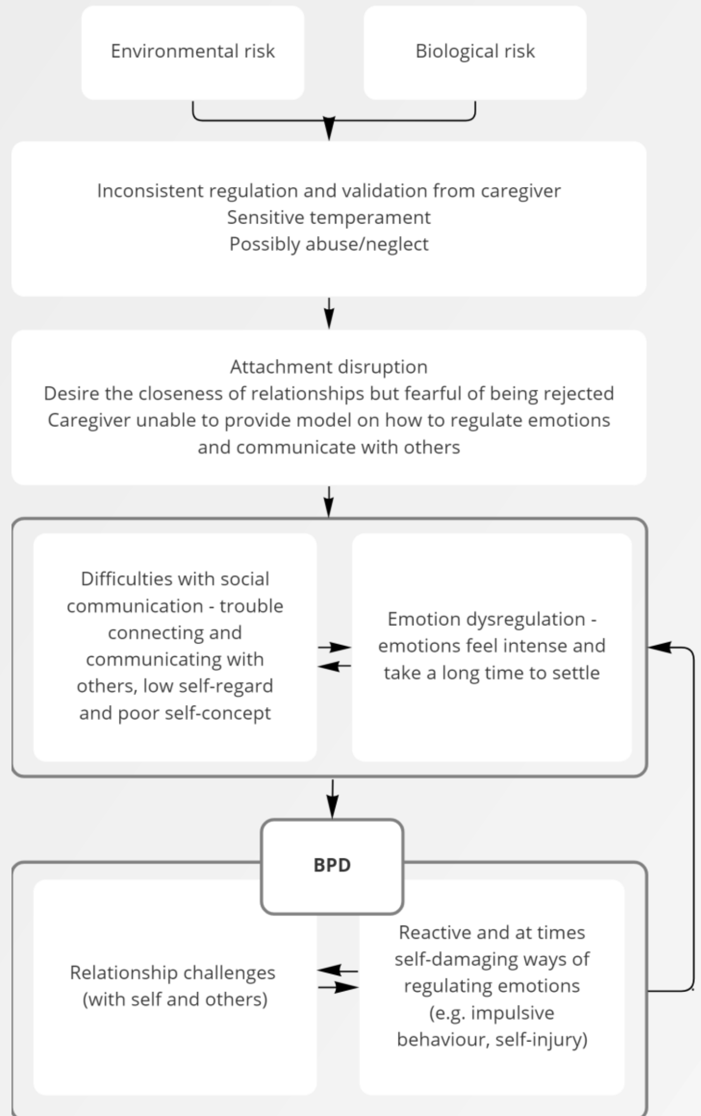
This resource was developed for the Rural Mental Health Partnership by Dr Caitlin Miller (Clinical Psychologist) at The Peregrine Centre. The Rural Mental Health Partnership is funded by NSW Health. We thank Dr Carla Walton (Centre for Psychotherapy Hunter New England Local Health District), Dr Michelle Townsend (University of Wollongong), and Mahlie Jewell, M.AThR (Peer Art Psychotherapist, Living Arts Therapy) for their valuable contributions to this resource.

How can a person develop a diagnosis of BPD?

As we currently understand, BPD develops from an interaction between environmental and biological factors. Biological factors may include genetic risk (research shows an estimated heritability of 40%), pre-natal exposure, maternal anxiety and depressive disorders, and emotion dysregulation in parents and attachment figures. Environmental factors can include oppressive systemic factors, trauma and family mental health concerns.

Individuals with a diagnosis of BPD may have experienced early attachment stress. This can occur when caregivers are unable to provide consistent, validating and comforting responses in early life and instead respond inconsistently or harshly. Traumatic events in relation to caregivers can also create challenges with attachment and security in later life.

This means that individuals with a diagnosis of BPD may miss early learning and skill development in regulating their emotions or understanding their experiences, which then results in difficulties within social environments and feeling like emotions are intense, out of control and unable to be settled. As people with a diagnosis of BPD often haven't had the chance to learn positive ways to regulate intense emotions or communicate with others, they may develop patterns of unhelpful survival behaviour to meet these needs. These behaviours can become difficult to disengage.



Note - this is a general overview of lifespan development of BPD, people with a diagnosis of BPD are a heterogenous group and this will not reflect each person's experience. Based on aetiological model reported in Winsper, 2017

Is BPD the same as Complex Trauma?

Experiencing prolonged or repeated incidents of neglect or abuse, occurring in a caregiving relationship in childhood or adolescence (often referred to as complex trauma), increases risk of developing BPD. Many individuals with a diagnosis of BPD report traumatic events. There is an agreement that child maltreatment and attachment difficulties can contribute to developing BPD.

Some experts in the field consider BPD a disorder of emotion dysregulation, while others see it as being a disorder of complex trauma. It is important to understand how each individual you work with makes sense of their experiences, as this can inform your treatment approach. Different models of treatment think about BPD in different ways based on these ideas. The outcomes tend to be similar across different treatments.

Being mindful of language

Focus on using language that identifies the person before the diagnosis. Describing someone who *has* a diagnosis of BPD, rather than using their diagnosis as a label for the individual shows respect and that an individual's mental health concerns do not define them.

Avoid saying things like "the borderline" or "being borderline". Preferred language includes: "diagnosed with BPD" or "individual living with BPD" as many people with a diagnosis of BPD can adopt the language they hear about themselves and many live with high levels of self-stigma.

Click here for a guide on recovery oriented language use, and click here for a guide on appropriate language for BPD.

Why can working with people diagnosed with BPD feel overwhelming?

There is a history of stigma about people with a diagnosis of BPD, with people being labelled as 'manipulative' or 'attention seeking'. This stigma probably comes from a combination of lack of understanding of the experience of people with symptoms of BPD, anxiety from clinicians about responding to reactive behaviours and interpersonal styles, and difficulties with the general mental health system for these consumers.

Practitioners can be anxious about working with symptoms that include heightened emotional reactions, self-punishing behaviours, impulsive actions and high levels of suicidality.

Therapeutic relationships with people with a diagnosis of BPD can be challenging for all parties. Many have not experienced healthy relationships that provide a sense of safety and meet their needs, and can find it difficult to trust others including health professionals.

Sometimes, people with a diagnosis of BPD have had to escalate their pattern of behaviour to get their needs met and for others to take their concerns seriously. This can become their relationship "template" and way of relating to others.

The therapeutic relationship can act as a mirror of other relationships. Noticing *how you feel* when engaging with an individual with BPD can help you understand *how other people* in their life may feel, and can help guide therapy tasks.

When individuals have been struggling for a long time there can often be a sense of hopelessness or passivity, or alternatively high hopes for what you can offer as a practitioner. It is important to communicate openly and honestly about what you can and cannot offer in your practice.

Understanding more about BPD, which can include reading current research, engaging in training from experts in the field and active self-care and reflection, can help you to feel more confident and can help you convey hope and compassion to your client.

Working with people with BPD is also meaningful work and can be a place where important change can be actively seen.

Individuals with a diagnosis of BPD are often passionate, empathetic, kind and thankful for the dedication of those that take the time and space to hear their experiences, hold hope for them and actively support and encourage them. For many, this might be a new experience and one they feel undeserving of. Working with this population can take time and is also incredibly rewarding.

How effective is treatment for symptoms of BPD?

It's important to know that symptoms connected to BPD respond to appropriate treatment. Whilst several years of treatment is typically required for those with longer-term unresolved symptoms, significant gains can be made in a short time period.

Psychotherapies often reduce the severity of BPD symptoms, and there is evidence that treatment helps reduce suicidality, self-injurious behaviour and hospitalisation. You can find a review of psychological therapy for people with BPD here.

Longitudinal studies show that over time, a high proportion of individuals with a diagnosis of BPD achieve symptomatic remission (they no longer meet diagnostic criteria for two years or more).

Evidence-based treatment for BPD

You can find general guidelines for the treatment of BPD here:

Royal Australian and New Zealand College of Psychiatrists and Your Health in Mind

Project Air Strategy treatment guidelines

NICE guidelines – Borderline personality disorder: recognition and management

Main evidence-based talk-therapy treatments for BPD
Dialectical Behaviour Therapy
Schema Focussed Therapy
Mentalization Based Therapy
Transference Focussed Therapy
Good Psychiatric Management

There are several psychotherapeutic treatment approaches that have evidence for treatment of BPD, with no one treatment being superior. International research also supports the use of peer support and non-talk therapy including arts and creative therapies.

Inpatient hospitalisation is indicated for individuals with a diagnosis of BPD only for crisis care and stabilisation, as evidence shows that extended hospital admissions can cause further difficulties.

Pharmacological treatment should be used with caution and is not considered a primary treatment for individuals with BPD. Pharmacotherapies may be considered for treatment of comorbid mental health concerns, and selectively for brief periods of time during a crisis.

It is recommended that you become trained in an evidence-based treatment for people with a diagnosis of BPD should you work with this population.

There can be unverified information on the internet or through social media of individuals who do not have education or training in BPD, which can perpetuate stigmatising attitudes.

Instead of relying on this information, consider sharing information from the following trusted sources:

- Project Air Strategy
- Orygen
- Spectrum
- BPD Collaborative
- Australian BPD Foundation

It is important to access supervision from a senior colleague or mental health practitioner if you are working with people with BPD, to help you work through any feelings you have and how to manage this while working effectively with individuals with a diagnosis of BPD. Practising active and authentic self-care and managing the emergence of burnout and compassion fatigue is vital.

What do I need to do in my first session?

Remember to always treat the person with compassion and express hope for positive change. Spend time in your first interaction to orient the individual with a diagnosis of BPD and discuss expectations. This might include:

- Explaining informed consent, confidentiality and limits to this, and explaining rights of individuals
- Discussing the recommended frequency and length of time of treatment and problem-solve any barriers
- Providing information on the services you can provide and for how long, including session length and what they can expect in terms of contact outside of your sessions
- Clearly identifying any relevant referral pathways or other services involved and explaining to the client the purpose of these services
    - It can be difficult for clients to navigate the health system and people with a diagnosis of BPD can find it challenging to find services, as treatment is often located in metro areas, is expensive, and often has long waitlists
    - Providing clear information on different services involved allows the individual with a diagnosis of BPD to take control of their treatment
    - Consider using the Project Air Strategy Care Plan to identify other treating team members
- Challenges with maintaining safety and trust in relationships can be present for people with a diagnosis of BPD. Change, breaks and ending in therapy can be difficult to process, and it is important to discuss treatment ending from the first session
    - Link ending therapy to the goals of the client and create a plan around this together – focusing together on tasks to help them live a meaningful life, and increasing their capacity to do this independently over time
    - Any ending of treatment or transition of service can result in high levels of distress. Plan these changes carefully and have a phased approach if possible
- Consider a diagnosis if appropriate, and explore how this fits for the individual

Who should be included in treatment?

- Ask the individual with a diagnosis of BPD about who they would like involved in their care
- If support people are involved and your client consents, include them in consults to provide further information and assist with treatment including safety planning
- Provide supporters with a copy of the safety plan if you have consent. Ensure the focus is on how to support the person with a diagnosis of BPD
- Encourage supporters to engage with their own mental health support and discuss how this can support modelling of positive behaviour for the person with a diagnosis of BPD

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How do I include other treating team members?

- With the consent of your client, liaise with other health professionals in the team
- People with a diagnosis of BPD may have strong feelings – including feelings of connection or mistrust – about people on their treatment team and likewise healthcare professionals may have strong feelings about people with a diagnosis of BPD
- This can occur for many reasons including mutual connection, difficulties with trust, challenges with appropriate boundary management by health professionals and different perspectives of care
- This can sometimes cause challenges for healthcare teams, where team members may experience polarised and strong opinions about care, and can lead to professional conflict. This has been referred to as 'splitting', though this term places the blame on the person with a diagnosis of BPD and does not consider the role of the treating team
- Treating team members should prioritise meeting together to discuss a shared understanding of what is occurring, reflect on how their own experiences and views may impact their actions and make a plan to move forward cohesively

How do I manage safety concerns?

Individuals with BPD often experience chronic suicidality and can also experience acute risk issues.

Safety plans should be developed with an individual *when they are not in crisis.* Safety planning should be completed collaboratively with a client, paying attention to their specific circumstances and what works for them, rather than being imposed on a client. Make sure you discuss together why and how to use the safety plan between sessions and how you will both proceed if a crisis arises. Safety can be assessed during your consults using the Linehan Risk Assessment and Management Protocol or clinical questions such as this example. Safety plans should be written, reviewed regularly and, with permission, shared with support people and other members of the treating team

Example safety plans:

- Project Air Strategy
- Beyond Now (also available in the Beyond Now app)

This article provides a guide on suicide risk formulation based on prevention rather than prediction

A safety plan should include:
Potential external events that may increase risk
Warning signs and symptoms (thoughts, feelings, behaviours, what others notice)
Self-management strategies and reasons for engaging in these Behaviours that are unhelpful and how to avoid these
How to reduce lethal means and maintain a safe physical space
Friends or family that can assist with connection or with accessing crisis care
Plan of how to access crisis services outside session if required to maintain safety

What do I do if my client presents in crisis?

- Assess safety and if necessary direct client to access crisis care
- Focus on the immediate concerns and stick to ways the client can use skills to tolerate their distress
- People with a diagnosis of BPD may have previously felt they are only listened or responded to when they talk about high-risk behaviours, as this might have been all they were asked about and the only time they received care. If your client is open to this, work together on ways that might meet their needs in a way that isn't harmful
- Try to respond calmly and in a validating way to high-risk situations while prioritising safety and without becoming distressed yourself. Ensure you maintain consistency of care over time so you don't send the same message that care is only provided when self-damaging or risky behaviours are present

Distinguishing between chronic and acute risk

- Identify a baseline level of risk using the safety assessment tools above. If possible and with consent, check in with their support network around what is the typical experience of suicidality for your client.
- Ask regularly if there has been any change to the initial risk level
- Pay particular attention if a client reports having an increase in risk e.g., having more frequent risk thoughts, risk thoughts becoming more intense or more detailed, change in behaviour such as increased unhelpful behaviours or collecting lethal materials, change in intent to act. These factors may indicate a change from chronic to acute risk
- Ensure you complete a thorough risk assessment if this is the case, and follow the safety plan you and your client have developed

There's so many things going on, what do we focus on in session?

Individuals with a diagnosis of BPD may be experiencing many challenges, which may lead to attempts to avoid or escape emotions, emotion dysregulation and unhelpful behaviours. Often people need to learn skills or strategies to manage and changes these patterns.

It can be helpful to:

- Work as a collaborative team
- Develop an agenda together with your client for the session to identify what their priorities are and what you want to work on together. Ensure you inquire about any harmful coping mechanisms or life-threatening behaviour.
- Identify action-oriented goals to work on with a focus on functional outcomes (work and relationships) driven by the individual with BPD. Focus on identifying short and long-term goals.
- Explore helpful strategies and skills to utilise in times of crisis.

For some people with a diagnosis of BPD, it can be difficult to identify goals or let themselves feel hope for the future. Show that you have hope that they can develop new skills and strategies.

Change can be difficult and take time and often people need support to persevere. Validate that unhelpful behaviours may be effective in some ways (i.e., providing immediate relief, helping to receive care from others, numbing from emotions, feeling in control) but can often lead to longer-term problems. Invite the person to consider whether this behaviour is still working for them. Reinforce that trying to change patterns of behaviours is difficult but worthwhile, and convey a message of hope for the future.

Your client with a diagnosis of BPD might also be interested in learning more from others with lived-experience by looking into:

Australian BPD Foundation
BPD Awareness
Emotions Matter
Borderline Arts

Dealing with relationship ruptures

Given individuals with a diagnosis of BPD can find it difficult to feel safe in relationships, it is possible you will have a 'rupture', if something you do or say that is experienced as hurtful by the individual you're working with. You might notice your client:

- Becomes less engaged or withdraws suddenly in session
- Appears upset or frustrated
- Starts cancelling sessions or arriving late for sessions

If this happens, model to the client how people with healthy relationships repair relationships by encouraging open and honest conversation about this and practising accountability where appropriate. Acknowledge that you can understand why the incident may have impacted them in light of their experiences with previous relationships and reinforce your support of them. Make sure that, while doing this, you stick to any boundaries you have implemented and explain the rationale for these. Work together on a plan for how to continue to have open discussions about the therapeutic relationship and move forward collaboratively.

Managing challenging interactions

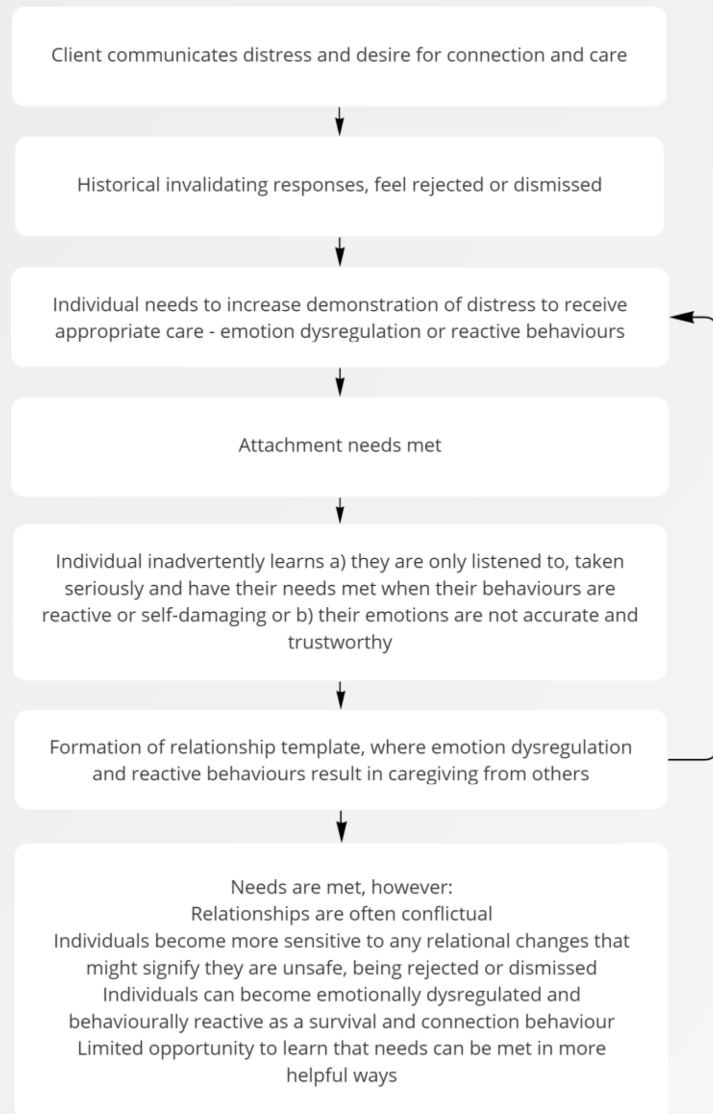
People with a diagnosis of BPD might also engage in behaviours when trying to protect themselves that professionals may experience as treatment interfering, and it can be challenging to refocus the treatment.

These behaviours may include; feeling unable to acknowledge their challenges, finding it hard to maintain boundaries (e.g., contacting their health professional outside of agreed upon times), and attending sessions late or not at all. They may struggle to regulate strong emotions and so react by speaking in a way that is perceived as emotionally or physically threatening. *It is important to reinforce and discuss that aggressive and violent behaviour is not acceptable in any circumstances.*

When setting boundaries or limits, focus on being warm and validating, understanding what need might be underlying the behaviour, and at the same time be firm around what is required and acceptable.

Ensure you act with compassion and respect to mirror this behaviour for the client.

- Try focusing on validating the emotion and the purpose of the behaviour, while setting boundaries around any inappropriate behaviours. As much as possible, explain the reason for the implementation of the boundary so the client can understand the rationale
- If a client reports increased risk as a response to you implementing a boundary, calmly and compassionately help them to use their safety plan.
- Help the individual learn what to do differently by being clear about what other actions they can take, and explore together alternative behaviours they could try



While they can be difficult, relationship ruptures and challenging interactions can also be important opportunities for the therapeutic relationship to be strengthened and can lead to stronger and more connected relationships over time. Fostering a strong therapeutic relationship can be highly reparative for people with a diagnosis of BPD, and can facilitate a space for meaningful therapeutic work and change.

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