



Borderline Personality Disorder in the Emergency Department: Good Psychiatric Management

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Abstract: Patients with borderline personality disorder (BPD) are high utilizers of psychiatric emergency services and present unique challenges in that setting. Frequently advised to visit an emergency department (ED) if safety is in question, their experiences once there often do not have beneficial effects. Issues specific to patients with BPD in the ED include volatile interactions with staff, repeat visits, concerns about safety (and liability), and disposition. Emergency department staff attitudes toward these patients are frequently negative when compared to patients with other diagnoses, and can detrimentally affect outcomes and perpetuate stigma regarding BPD. These attitudes are often due to lack of education and training about how to understand, approach, and treat the patient with BPD. The limited literature regarding the treatment of BPD in the ED offers few guidelines. This article presents an approach based on Good Psychiatric Management that can reduce negative reactions by ED staff and make ED visits more effective and less harmful. Relevant principles include psychoeducation, the reinforcement of the connection between symptoms and interpersonal stressors, and employment of an active, authentic therapeutic stance. Training ED staff in these principles could lead to attitudinal changes, reduced stigma, and potentially improved outcomes.

Keywords: borderline personality disorder, emergency department, Good Psychiatric Management, training, treatment

INTRODUCTION

Patients with borderline personality disorder (BPD) are high utilizers of the psychiatric emergency department (ED), representing approximately 9% of all visits.¹ They present a unique set of challenges, including disposition problems, high levels of frustration among staff who manage them, and an increase in disruptive behaviors when compared to other diagnoses.² They also more frequently present as repeat visitors compared to those with other diagnoses.^{3–5} Given the tendency for recurrent visits, the psychiatric ED often becomes an integral part of treating BPD patients. ED visits are opportunities to augment and stabilize outpatient care. ED providers can reinforce the outpatient treatment, especially in settings where robust outpatient care options are not otherwise available. The psychiatric ED setting is itself one of inconsistency, however, as many staff are transient (moonlighting physicians, part-time workers), with varying levels of training (residents, interns, students); workloads fluctuate, as does the availability of inpatient beds. Furthermore, the nature of shift work may beget a sense of ambiguous and limited ownership of patients and their outcomes.

Patients with personality disorders are likely to present with recurrent suicidality, further increasing the pressure on ED staff, due to the high-risk nature of the disposition and liability concerns.⁶ High rates of comorbidity (mood disorders, anxiety disorders, substance use disorders, and eating disorders) among BPD patients further complicate matters.⁷ BPD patients are often advised to visit the ED when in crisis and when safety is in question, but experiences in the ED can damage the patient and undermine treatment progress. Staff may be well-intentioned, yet issues of fatigue, frustration, and lack of specific training in treating BPD are common. Additional challenges may include the frequent lack of suitable referral resources and the time constraints in the assessment process. An understanding of BPD patients in a psychodynamic framework, as discussed in past reviews, can be useful, but most staff in the psychiatric ED lack such training.^{8,9} Likewise, principles of other evidence-based treatments can be and are used by some ED staff, but the dearth of providers with training in those modalities calls for a more practical, generalist model to address the psychiatric management of the BPD patient in that challenging setting.

While this article focuses on care of BPD patients in the psychiatric ED, the associated problems are only heightened in the medical ED setting, where the lack of appropriate training is more pronounced, and with far less access to dedicated psychiatric resources. Many medical EDs have limited access to psychiatric consultation or lack effective relationships with psychiatric inpatient units—which leads to “boarding” of patients in the ED until a suitable transfer or admission can take place. Furthermore, the number of psychiatric patients seen

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in the medical ED setting is rising steadily, possibly due to the significant reduction in inpatient hospital beds without a concomitant increase in community services and resources.¹⁰ A survey of medical ED directors indicated that, after the decision to admit has been made, 60% of psychiatric patients are “boarded” for more than 4 hours, 33% for more than 8 hours, and 6% for more than 24 hours; most patients did not receive any psychiatric care during that time.¹¹ Another study indicated that ED length of stay was significantly longer for psychiatric admissions (18.2 hours) than for nonpsychiatric admissions (5.7 hours).¹² Further exploration of whether the principles and approaches outlined in this article could be effective in the medical ED setting would be useful.

Staff Attitudes

Reactions of psychiatric ED staff toward patients with BPD can range from empathic to caustic, dismissive, and distant. Many of the problems that arise in managing BPD patients result when staff reactions, including hostility, withdrawal, helplessness, anxiety, and rescue fantasies, influence the staff’s behaviors and decision-making abilities.¹³ Treating patients with BPD optimally in all settings, and certainly in the psychiatric ED, is possible only if one is able to recognize, and then control, such responses. If dysfunctional staff attitudes persist, problematic outcomes can include unnecessary hospitalizations, inadequate safety assessments, superfluous use of medications, excessive use of physical restraints, and, ultimately, increased liability (see Table 1).¹⁴ Among the reasons for negative provider attitudes are lack of confidence in treating BPD patients and beliefs that BPD is intractable or that such patients are manipulative.^{15,16} Compared to staff in other treatment settings, ED staff may have especially negative attitudes toward BPD patients who self-harm.¹⁷

The emotional dysregulation and hypochondriasis so common in BPD patients can lead to hostility and dysregulation in their mental health providers.^{18–20} The often inadequate interview spaces, lack of appropriate disposition options, and limited time with which to assess patients in the psychiatric ED only heighten the tension.⁸ Some negative reactions are related to the chaos that BPD patients in crisis can cause, but others are stigma driven. If unrecognized and unchecked, these reactions can trigger hostility toward, or emotional distancing from, the patient.²¹ Whether negative reactions are founded on stigma or on the patient’s actual presentation, it is important for providers to manage such reactions so that optimal treatment can be provided. Given that patients often visit the ED in their most hopeless condition, if they interpret treaters’ negative attitudes as the loss of their last line of support, the risk and liability associated with BPD patients can only escalate.

Good Psychiatric Management

Given the numerous challenges in managing BPD in the psychiatric ED, deliberate and skillful interventions are needed to render thoughtful and effective treatment. Good Psychiatric Management (GPM), a straightforward, empirically validated approach to treating BPD patients, offers both pragmatic principles and an optimistic approach.^{22,23} GPM can be employed by mental health professionals without extensive training, allowing them to become “good enough” to be helpful in the psychiatric ED and other settings. Since the long-term prognosis for most BPD patients is good, a sound goal of ED treaters is to minimize excessively intensive interventions and to avoid causing iatrogenic harm while containing intermittent crises.²⁴

Among the GPM principles that could improve ED care of BPD patients are psychoeducation, the focus on interpersonal stressors, and the employment of an active, authentic,

Iatrogenic action	Likely causes	Potential consequences	Productive alternatives
Unnecessary inpatient hospitalizations	Reacting to fears of liability, emphasizing chronic (over acute) risk factors, equating self-harm with suicidality	Reinforces hospitalization as the best answer to short-term crises	Work actively with patients and their families on safety planning and improving social supports
Inadequate safety assessments	Staff fatigue, poor transitions of care, underutilization of collateral information (e.g., outpatient providers and social supports)	Heightens safety risk and increases liability	Be aware of provider fatigue, engage in formal sign-outs with written recommendations, make efforts to contact outpatient providers and social supports
Excessive use of medications	Provider frustration, insufficient verbal de-escalation (due to lack of training or time), patient or provider seeking a “quick fix”	Frames medications as the solution, subjects patients to adverse side effects	Actively express support, provide psychoeducation regarding medications in BPD
Hostile or dismissive staff behavior	Excessive countertransference or transference reactions	Exacerbates patient’s hopelessness, worsens stigma, increases liability	Recognize negative reactions and adopt a more hopeful, positive attitude

but not hyperreactive or overinvolved approach (see Text Box 1). The use of these principles can help ED staff manage core clinical problems by rapidly building an alliance, by managing suicidality and nonsuicidal self-injury in a rational and sensitive manner, by using psychopharmacological interventions appropriately, and by managing family involvement.²² If sufficiently educated in these principles, psychiatric ED staff can fulfill their roles as essential and valuable members of the BPD patient's treatment team.²⁵ Training in GPM can be conducted relatively efficiently, using workshops and the GPM manual, and its application may not require ongoing training.

CORE PRINCIPLES

Psychoeducation

Psychoeducation is a core principle to be used in the psychiatric ED, beginning with discussion of the diagnosis. Psychoeducation provides a platform contextualizing the patients' emotions and behaviors, engenders a feeling of hope, and helps set realistic expectations.²² Additionally, some evidence suggests that psychoeducation early in the treatment of BPD may both reduce impulsivity and help stabilize the BPD patient's relationships.²⁶ Most importantly, patients and their families should understand that BPD is significantly heritable, that BPD patients are very sensitive to environmental stress, and that there are neurobiological underpinnings to their symptoms and behaviors. Furthermore, they need to know that most patients with BPD get better and stay better, and that evidence-based treatments are available.^{24,27-29}

Given the time limitations and a potential lack of collateral information in the psychiatric ED, making an initial diagnosis of BPD and disclosing it to the patient is not standard practice in that setting. But in the case of a patient who presents frequently to the ED, is known to staff, and clearly meets criteria for BPD, a provider may have sufficient evidence to more confidently give the diagnosis. A frank discussion, though short of a diagnosis, can also be useful (see case vignette below) when an obvious pattern of symptoms and behaviors indicates BPD as a likely factor (comorbidities notwithstanding). Furthermore, since patients with BPD will often present with a history of multiple diagnoses, discussion of the likely BPD diagnosis may prove helpful in explaining their poor or limited responses to past treatments.

Text Box 1

Relevant GPM Principles in the Emergency Department

- Engage in psychoeducation about BPD
- Be active and authentic when communicating with the patient
- Imbue therapeutic interactions with the expectation of positive change
- Encourage the patient to actively participate in treatment
- Focus on interpersonal relationships and stressors

Reading materials could also be given to the patient as an adjunctive learning tool.

Focus on Interpersonal Stressors

Interpersonal stressors often prompt substance abuse, dissociation, self-injurious behaviors, suicidal acts, depression, or anxiety in BPD patients.³⁰ GPM's focus on interpersonal stressors is a particularly relevant tool in the psychiatric ED setting, for it helps clinicians expeditiously locate the source of the presenting crisis. The identification of inciting interpersonal events may in itself help regulate and organize the BPD patient in crisis. Active inquiry about the patient's relationships prompts the BPD patient to consider how recent interpersonal interactions may have contributed to the ED visit. What follows such insight can be an active, productive discussion between patient and provider regarding both interpersonal stressors and, potentially, ways in which a future crisis might be avoided. This process also reminds patients of how deeply they can be affected by interpersonal relationships—thus leading to further insight (see case vignette). A common problem in the psychiatric ED is that BPD patients may present with vague or global complaints (e.g., anxiety or depression) while avoiding or failing to recognize the relevant interpersonal issues. Illuminating the role that interpersonal stressors play in the patient's symptoms and behaviors can be very effective. When a patient is unwilling to discuss relationships and life situations with treatment staff, the provider should explicitly communicate that this unwillingness limits the staff's ability to help.

Taking an Active, Authentic Therapeutic Approach

When engaging with a BPD patient in the psychiatric ED, time is limited, and the treater's therapeutic stance is essential; GPM proposes one of activeness. The volatility of BPD patients can peak in this setting, and actively engaging the patient, while tempering one's own emotional reactivity, is key.²² This is not the time for a distant, "hands off" approach, which would likely trigger a negative response and undermine a therapeutic alliance. Conversely, a hyperreactive response to the BPD patient, particularly in relation to emotional instability, anger, suicidality, or self-injurious behaviors, can lead to unhelpful interventions, such as unnecessary hospitalizations and use of non-indicated medications. Asking BPD patients to consider how the ED visit might be helpful encourages them to think for themselves and to actively implement solutions to their problems. If the patient prefers to be hospitalized, the ED provider can express doubt about the utility of hospitalization (particularly if the patient has been hospitalized numerous times without any particular improvement) and can review the pros and cons of that intervention.

Approaching the patient in an intentionally authentic manner encourages a therapeutic alliance by helping the patient understand that the relationship is a real, albeit professional, one and that the provider cares about the patient's well-being.

While difficult in a setting in which time is limited and the stress level is high, showing authentic interest and concern assists in quickly establishing rapport. This should be done with a concomitant focus on improving patient's lives and relationships outside of treatment, so as not to reinforce the feeling that the ED is the only place to turn when in crisis or feeling lonely and misunderstood. Provider self-disclosures, such as acknowledging mistakes or normalizing irrational thinking when under stress, can help establish that the relationship between patient and provider is a safe, nonjudgmental one in which it is safe to discuss difficult topics. This approach models an effective interpersonal communication style and reinforces the idea that relationships are dyadic—that is, that each interacts with and affects the other—and that the provider takes them seriously (a form of validation). The provider's authenticity allows the patient to communicate more freely, which is essential to an optimal disposition.²²

CORE CLINICAL PROBLEMS

Managing Suicidality and Self-Harm

Suicidality and self-harm are the behavioral hallmarks of BPD, and their management in the ED setting requires a measured, rational approach in order both to reduce risk and to avoid undermining the patient's progress. Fears with regard to liability and patient safety are fundamental challenges for clinicians in the psychiatric ED. Central issues in this context include methods of reducing liability and how to interact with a patient who has attempted suicide or engaged in self-injury.³¹

It is important to recognize the “acute on chronic” model for BPD patients. A baseline level of suicidality is often chronic, superimposed on which are suicide attempts that are often ambivalent and self-injurious behaviors without actual suicidal intent.²² Providers may inaccurately equate self-injury with suicidal behavior, which can result in unnecessary hospitalizations and ED visits (see case vignette). While suicidal thoughts or self-injury may trigger the ED visit, it is critical to assess the actual dangerousness of the patient, which typically involves exploring acute stressors and understanding the true meaning behind suicidal threats and statements. Acute suicidal risk in BPD is elevated by active comorbid substance abuse, a concurrent major depressive episode, and interpersonal stressors, including the loss or perceived loss of support (see case vignette).^{32,33} As with any suicide-risk assessment, the treater should explore with the patient any intense wishes to be dead, as well as any specific suicidal plans.

Regardless of the ultimate disposition, and no matter how recurrent the behavior, treaters must always respond initially with concern, attempting to rapidly build an alliance with the patient to further a reasonable and safer outcome. The frequent phenomenon of BPD patients desiring an inpatient admission despite the lack of objective risk factors can fatigue and frustrate providers, and may trigger

unnecessary inpatient admissions or protracted ED stays. It is important to be aware that there is no evidence that such admissions reduce suicide risk or contribute to a better long-term prognosis.

Although liability is naturally a concern when dealing with a group of patients for whom suicidal thoughts, attempts, and completions are frequent, there are ways in which risk can be reduced. One essential method involves collaborative communications with others in completing a thorough safety assessment. Speaking with family members and other supports who can provide additional information is useful and can inform a safety plan. Additionally, in the psychiatric ED, providers often have opportunities to make collaborative decisions with colleagues and, for trainees, with supervisors. Consultation with other ED team members and supervisors can reduce provider anxiety, assist in lightening the decision-making burden, and strengthen confidence in the disposition plan. At times, patients may protest or refuse to allow ED staff to contact others to collect additional information. However, when the patient raises the true potential for suicide, such communications are not at the patient's discretion (see case vignette). Procuring collateral information greatly decreases the liability risk and helps optimize care.

Frequent visits by the BPD patient to the psychiatric ED often indicate that the outpatient treatment is not working, thus making consultation and collaboration with the outpatient providers all the more crucial. With particularly high utilizers of psychiatric ED services, a treatment plan should be established in conjunction with the outpatient providers. This plan could then be kept in the patient's chart to support a more cohesive and less inconsistent approach to the patient's future care.

Another method of reducing liability is to recognize any excessive countertransference enactments, which can result in unnecessary involuntary hospitalizations due to feelings of anxiety or anger, or in premature discharges or dismissals of the patient's complaints due to feelings of helplessness and frustration.

In the aftermath of a suicide attempt or self-injurious behavior, a “chain analysis” of the events and emotions that led to the behavior is helpful in understanding the acute risk factors.³⁴ This process can illuminate the etiology of stressors and resultant behaviors, and contribute to problem-solving strategies to prevent recurrences (see case vignette).²² Reminding the patient of the (likely) interpersonal stressors triggering the crisis is important, as is actively engaging the patient in generating a “safety plan,” which would include how to avoid or reduce future crises, whom to contact (and not to contact) when feeling vulnerable, and mitigation of risk by locking up medications and securing or disposing of weapons. Ideally, the family and outpatient providers would be involved in this process. If the ultimate disposition is discharge home, one might even invite more worrisome patients back to the psychiatric ED for scheduled return visits if timely and adequate outpatient treatment cannot

be arranged. Having staff place follow-up phone calls may also be useful.

If the BPD patient does not have an outside provider, the challenges of finding community-based treaters or other supports in a timely fashion create additional safety risks. Some communities have disposition options such as partial hospital or even residential treatment facilities, but waiting lists or high costs of care may present barriers to access. When no care plan has been established, or when the acute risk is elevated above and beyond the chronic safety risk, inpatient hospitalization may well be the best and safest option—even when, from a longer-term perspective, it may not ultimately be helpful.³⁵ In such cases, after the decision has been made to hospitalize, an interactive discussion can be initiated to explain the short-term nature of the intervention and to help prepare the patient for life after discharge.

Psychopharmacology

There are no U.S. Food and Drug Administration–approved medications for the treatment of BPD, and no medication for its symptoms has been shown to be significantly or consistently effective.³⁶ However, BPD patients who present to the psychiatric ED with acute agitation or anxiety frequently receive medications (mostly benzodiazepines or antipsychotics).¹ Because of time constraints, a careful, supportive, one-on-one intervention by a staff member is often not immediately possible, and patients' behavior can present a danger to themselves or to ED staff, or can interfere with conducting an adequate assessment. In such cases, the use of medications is indicated.

That said, using medications to treat BPD in the ED may be harmful and can reinforce the behavior of utilizing the ED for temporary symptom relief. Medications should be administered only with the explicit provision that the patient appears unable to participate in a thorough assessment or is being disruptive. Patients should be informed, however, that reliance on medications is rarely beneficial in the long run and that they often have adverse side effects (see case vignette). Furthermore, changing BPD patients' medications is not advised while they are in crisis—and certainly not without discussing such changes with their outpatient providers (see Text Box 2).

Often a show of support and validation can go a long way to calming an agitated or anxious patient in the ED, thus reducing the need for medications. In addition, efforts to manage situational stressors can help stabilize agitation without subjecting patients to the possible adverse effects of medications, such as further disinhibition with benzodiazepines.

Family Involvement

While many BPD patients lack a supportive network of relationships, many have romantic partners or families with whom conflicts and difficulties are common. Skillfully addressing these relationships in the psychiatric ED is important, as loved ones often are confused and frustrated, have no clear sense of the patient's diagnosis, and do not know

Text Box 2 Medication Guidelines for Treating BPD in the Emergency Department

DO	Engage in psychoeducation about the role of medications in BPD
	Use medications to reduce agitation when danger to self or others is present
	Use medications to reduce anxiety interfering with a thorough assessment*
	Attempt verbal de-escalation before resorting to the use of a calming medication
	Emphasize psychosocial interventions as the mainstay of treatment, and frame medications as adjunctive at best
DON'T	Present medications as the treatment of choice for BPD symptoms
	Use medications in a hostile or punitive fashion
	Offer medications without explaining to the patient why you are doing so
	Make recommendations regarding the patient's medications without collaborating with his or her outpatient providers
	Significantly change medication regimens in the acute crisis setting

*Benzodiazepines, if prescribed, should be given in small amounts and presented as short-term interventions.

how to be of most help and to avoid exacerbating the patient's distress. It is usually best to start with psychoeducation about the diagnosis and its prognosis, origins, and treatability. Next, recommending several guidelines can be helpful. One is to "go slowly"—an explicit acknowledgment that change can be difficult to achieve in BPD and that realistic, achievable goals need to be set in collaboration with the patient. Additional recommendations are to "keep cool" (despite the patient's emotional lability and anger), to maintain home-life routines, and to discuss "light" issues (lest all discussions surround the patient's crises and associated drama). The clinician can also remind the family that, while the patient's self-destructive behaviors should never be ignored, staying calm and not overreacting are crucial. Emphasizing the benefits of collaboration between the family and the patient's treatment team is also important. Easily accessible guidelines are available and can be provided to families in the ED, to be used as a home resource.³⁷

CASE VIGNETTE

The following case is a composite and is not based on a real patient. The case will have decision points, with several possible responses. The reader is asked to consider each response in terms of its level of helpfulness. Each possible response will be followed by a brief comment.

Mary, a 21-year-old female undergraduate college student presents for the third time in a month to the psychiatric ED, with an increase in self-injurious behaviors, including cutting the words “hopeless” and “death” into her arms and legs. Her chief complaint is “depression,” and she says she is depressed because everyone hates her and she cannot trust anyone. After waiting for 30 minutes, she starts yelling in the waiting room, “When is anyone going to talk to me, I’m suicidal!” A nurse quickly shuttles her into an interview room. Mary says she feels agitated and states, “I can’t go home, I just don’t know what I might do.” Further questions by the nurse result in repeated statements of “I don’t want to talk about it.”

Decision Point 1: Responses and Comments

In response to the patient’s distress you

- A. *ask her if she would like a medication to calm her agitation.* Although a medication could calm her nerves, you have not yet explored together the steps that would help her to calm herself, an important skill for BPD patients to learn. Excessive or unnecessary medications can reinforce Mary’s sense that she cannot control her own emotions, and can also reinforce her sense of helplessness. Likewise, reinforcing the idea that a medication can help when she is in crisis could lead to expectations that medications are the answer to her troubles—which is unlikely to be the case, given the weak evidence base for medications in BPD.
- B. *do a comprehensive suicide-risk assessment.* While a suicide-risk assessment is appropriate at some point, it would be ill timed at this juncture and could potentially focus her attention on her suicidality and distract from examining possible interpersonal crises that are likely contributory.
- C. *arrange for inpatient hospitalization.* At this point, when the true meaning of her suicidal statements has not been discussed, arranging inpatient hospitalization is premature. A decision to hospitalize based on an incomplete assessment could undermine the patient’s self-reliance and could reinforce the patient’s perception that, rather than engaging in active problem solving, she should rely on hospitalization to cope with crises.
- D. *say that you’re not sure what she means by “I just don’t know what I might do,” and that she will need to explain more in order for you to help her.* Inquiring about the meaning of the patient’s statements allows for her active involvement in the treatment process and affords her the opportunity to reflect on her emotional state. BPD patients must know that the clinician is not omniscient and cannot know how best to help without the patient’s active participation.

With further investigation, Mary discloses that yesterday she discovered that her boyfriend cheated on her, which

evoked memories of past partners’ infidelities. She says, “See, you can’t trust people, they will always stab you in the back. I might as well just be lonely for the rest of my life or kill myself.” She reveals a long history of both cutting and suicide attempts, mostly by overdose. As you ask more about her history, she says, “I guess it’s the bipolar kicking in. My mood has been all over the place.” She adds she was previously diagnosed with bipolar disorder because of her unstable mood; upon further questioning, however, it is clear she lacks a history of distinct episodes meeting the criteria for mania or hypomania. She says, “Nothing helps, I’ve tried every medication out there, and none of them work.” She thinks that she may be a hopeless case, and doubts that she will meet anyone to love her. She cuts herself often, denies that it is a suicidal act, and says that it is “therapeutic.” She pulls up her sleeves to show her arms, and begins to cry uncontrollably.

Decision Point 2: Responses and Comments

With this further history in hand, you

- A. *ask if anyone has ever brought up the possibility of BPD.* Given that she does not experience distinct manic or hypomanic episodes and that her crises occur in the context of interpersonal stressors, her mood instability may more likely reflect BPD. Moreover, the presentation of self-injurious behaviors, interpersonally driven crises, and fears of aloneness make the BPD diagnosis quite clear. Given that the history-taking process has just begun, however, broaching the subject of a misdiagnosis here may derail efforts to build an alliance. There may be a future opportunity to further discuss her diagnosis.
- B. *emphasize the primary task of controlling her self-injurious behaviors.* Understanding the nature of her cutting behavior is important, but she has already reported that it is nonsuicidal in nature, which diminishes the importance of discussing it at this time. For many BPD patients, cutting does not equate to a suicidal act, and can sometimes be self-soothing.
- C. *underscore the importance of connecting her relationship troubles with her current self-harm behaviors and increased suicidality.* Often, an interpersonal event precipitates the crisis leading to the BPD patient’s ED visit. Focusing the discussion on how her relationship problems have acutely affected her mood and led to increased suicidal thoughts and self-injurious behaviors is most relevant at this point. It is best not to be distracted by other issues, as it is almost certain that her feeling rejected and devalued directly triggered her crisis and thus her ED visit.
- D. *advise the patient that you will attempt to speak to her outpatient providers.* Communicating with her outpatient treaters is necessary and crucial for adequate decision making. The ED clinician should not belabor this point, so as not to distract from the emerging narrative.
- E. *tell her she seems upset, and emphasize the importance of getting support around her difficulties.* This is essential.

Statements like these can help the BPD patient feel that the clinician is caring and concerned. A sterile, distant approach would likely further the patient's sense of abandonment and loneliness.

Attempts to contact the patient's outpatient therapist and psychiatrist were unsuccessful during previous visits to the ED, but this time, her psychiatrist is reached. She has been diagnosed with bipolar disorder and major depressive disorder, but a BPD diagnosis has not been disclosed, despite the patient meeting criteria. The psychiatrist explains, "I didn't want to upset her." Nonetheless, Mary has recently started weekly dialectical behavioral therapy, having been hospitalized seven times in the past year due to safety concerns, only to present to the ED days or weeks after discharge in yet another crisis. Her psychiatrist adds that Mary has tried numerous medications in the past, including alprazolam, buspirone, chlorpromazine, citalopram, escitalopram, fluoxetine, haloperidol, lithium, and paroxetine. Medication trials have not controlled her mood lability and have often caused adverse effects. The patient would like a medication change ("something stronger"); she is now taking aripiprazole, clonazepam, lamotrigine, quetiapine, trazodone, and valproic acid. She has gained 30 pounds in the past six months. She self-medicates with marijuana and alcohol, and has a history of a DUI. Her psychiatrist says that he is hopeless that the patient will ever get better. After finishing your conversation with the psychiatrist, you return to your interview with Mary. She looks weary and tells you, "My boyfriend just texted me. He keeps saying he wants me in his life. I don't know what to do with him."

Decision Point 3: Responses and Comments

After speaking to the patient's outpatient psychiatrist, you:

- A. *inquire about her substance use.* The timing and nature of this evaluation should be carefully considered, as substance abuse can be a symptom of BPD, and focusing on it too heavily may distract from the core issues. Nevertheless, she needs to be educated that abuse of substances can exacerbate self-harm and emotional dysregulation. In addition, she should be informed that several of her medications can interact dangerously with alcohol.
- B. *say you can understand why she feels that way about her boyfriend.* You yourself have been cheated on in the past, and it hurts. Measured self-disclosure is often helpful, as it can lead to the patient feeling more open to talking freely. In this particular case, however, getting too personal could encourage the patient's hope for a relationship that is not professional.
- C. *advise her to get her medications reevaluated.* Although a medication history is important to obtain, medications should not be the focus in a BPD crisis. In the acute ED setting, too much attention to medications can interfere with expeditiously reaching a suitable disposition. It took a long time to get Mary settled into her current

medication regimen, and it will take a long time to change it effectively. Those changes require implementation by her outpatient providers. It is also unlikely that the present, apparently short-term crisis can be solved by medication changes. That said, it needs to be highlighted that her symptoms have not been reduced by past medications or present polypharmacy. She should be cautioned that, given her symptomatology, medications are often not significantly or consistently helpful, and that they should be considered adjunctive to psychotherapy, not the mainstay of treatment. Side effects are likely with medications, and the stability of her relationships and work life are far more important than her medication regimen. The crucial point to communicate is that she needs to more skillfully control her emotions rather than to rely on medications to do so.

- D. *inquire more about her relationship, discuss recent events in detail, and explore how things could be different in the future.* Again, maintaining focus on the discrete, recent life events that led to her increased suicidal thoughts and self-injurious behaviors is likely to be an efficient strategy in the ED setting. Doing a "chain analysis" of how she ended up in such distress can be helpful in maintaining her active engagement and can serve as a segue into possible safety planning.
- E. *discuss her current treatment and how she feels it is going.* Discovering more about Mary's thoughts on her treatment will help shape an adequate follow-up plan if she is discharged to home. The patient's multiple visits to the psychiatric ED, along with repeated hospitalizations, indicate that the outpatient treatment has not been effective—perhaps because of the reliance on medications or other variables. Given the challenges of treating BPD in the outpatient setting, recurrent visits may afford opportunities for further discussion and for collaboration with her outpatient clinicians, particularly about the inefficacy and dangers of polypharmacy in treating BPD.

Upon more discussion of the current crisis, the patient discloses that her boyfriend is and always has been unsupportive and emotionally abusive; it seems she frequently falls into these types of relationships. She says she feels somewhat calmer and wonders whether her problems have less to do with bipolar disorder and more to do with her relationships with others. She reveals that she had been "hearing voices" telling her to kill herself but that they have now quieted down. She hears these voices when feeling upset, and they are derogatory in nature. She feels like "a screw-up" and asks what she should do at this point. You both agree that her parents should be contacted. When speaking to them on the telephone, they indicate that they are not surprised their daughter is in the ED. They have been concerned about the volatility of her relationship with her boyfriend. They say that while she has taken "serious overdoses" in the past, most of her suicide attempts involve "only a few

pills” and have not required medical treatment. They have wavered between a “tough love” approach, which included ordering her to get a job, and more gentle communication, which usually requires that they “walk on eggshells,” reluctant to upset her further. They have already spent considerable money paying for her treatment, and feel that they should give up on finding a “cure.”

Decision Point 4: Responses and Comments

Given the parents’ reports, which better inform your understanding of the patient, you

- A. *review the criteria for BPD and ask her if she feels that it fits.* She has provided an entrée into a discussion of BPD, and as noted, psychoeducation about the diagnosis may help explain the mystery of why past treatments have failed. Discussing BPD here could also help focus her expectations, trigger insight into her emotions and behaviors, and engender a feeling of hope for the future. “Officially” giving her the diagnosis of BPD is premature if she objects to it, but her consideration of possible BPD might more reasonably inform her expectations and treatment.
- B. *discuss her relationship with her parents.* Her relationship with her parents is likely to be stressful but also important to her success, particularly because of her current financial dependence on them. Emphasizing and normalizing that the relationship may be difficult for many reasons—and due to the behaviors of both parties—is important. It may be helpful to underscore that nothing is “all their fault” or “all her fault,” that responsibility for missteps can be shared, and that dysfunctional interpersonal behaviors can be modified through training and practice. Mary’s parents can also be given basic guidelines on how to interact with her, which may prove helpful.³⁶
- C. *ask her what she thinks will help at this point.* It is important to encourage BPD patients to think for themselves, particularly if their affect is regulated enough for them to reason. Asking this type of open-ended question here affords her an opportunity to more actively participate in her own treatment, and can help foster a sense of agency and self-reliance.
- D. *engage the patient in a detailed discussion about her suicidality and whether or not she should again be hospitalized.* Throughout the interview you have assessed her safety. Imposing further discussion of suicide now, after she has indicated to you that she has moved away from active suicidal thoughts, would be a reflection of your own anxiety. Differentiating between suicidal statements and true suicidal intent is essential. You have presumably done so without overreacting, reinforcing the use of suicidality as a cry for help, or introducing hospitalization.

After reviewing the criteria for BPD with you, the patient says that it “sounds like me” and seems to more fitting than bipolar disorder. She feels that she can contact her parents

should her suicidality increase, and she reasserts that her cutting behavior was intended to reduce her “emotional pain” and not to kill herself. She says that she cannot promise to stop cutting herself but that she feels safe going home. Her psychiatrist agrees to see her in several days.

Decision Point 5: Responses and Comments

In order to wrap up the case, you

- A. *reinforce the value of continuing treatment, telling her that things can get better and that she can become her own agent of change in her moods, behaviors, and relationships.* Expecting positive change and communicating that expectation to the BPD patient can help reduce feelings of hopelessness. It is also important to underscore the patient’s need to participate in her own recovery, both in sessions with her providers and in her life outside of treatment.
- B. *ask her what changes she can make to help life be more palatable.* Actively exploring specific and concrete ways in which she can mitigate future crises by reducing interpersonal stressors is paramount in this discussion.
- C. *encourage a consultation from a new psychiatrist, one with more expertise treating BPD.* Care should be taken not to undermine Mary’s relationship with her current providers if she appears to be attached to them. For now, it may be sufficient that you have already spoken with her current psychiatrist about her medications and the BPD diagnosis, and that you have also consulted with her family.
- D. *write up a “safety plan.”* A safety plan, especially if produced by the patient, while not necessarily a meaningful contract, can help to emphasize coping strategies to use when feeling unstable. The plan serves as a concrete document to refer to when the patient is overwrought, and it can inform helpful action steps in a future crisis. Ideally, such a plan would be created in conjunction with the outpatient team and the BPD patient’s family.

DISCUSSION

Given the numerous challenges of managing patients with BPD in the psychiatric ED setting, a practical and effective approach is needed. The psychiatric ED has become a crucial part of the mental health system, acting as a bridge between outpatient and inpatient services and as a third treatment setting, particularly for recurrent visitors, of whom BPD patients are among the most frequent. Each visit can be seen as an opportunity to reinforce Good Psychiatric Management principles to bolster the outpatient treatment, and could potentially lead to a reduction of future ED visits, suicidal behavior, and hospitalizations. The principles outlined here reflect a rational, informed approach to treating and thinking about BPD patients, but they have not been empirically tested in the psychiatric ED setting. Further research would be helpful in determining if the implementation of these principles actually leads to improved outcomes.

Training staff in GPM of borderline personality disorder may contribute to a more uniformly educated team of providers, and can engender hopeful, less stigma-driven treatment, grounded in a knowledge base rather than conjecture. This approach leads, in turn, to the crucial psychoeducation of patients and their families. Although psychiatric ED providers typically operate under time pressure that precludes extensive discussions or that might be taken to militate against the use of GPM principles, the clinician's use of those principles may ultimately save time and serve to avoid common pitfalls that can prolong the ED visit. In particular, focusing on interpersonal crises, maintaining an active therapeutic stance, and employing a rational and collaborative approach to evaluating suicide risk may help to clarify the impetus for the ED visit, hasten development of a therapeutic alliance, and aid in disposition decisions.

In conclusion, the psychiatric ED setting, despite its challenges, affords excellent opportunities for improving the care of BPD patients. Providing psychoeducation to patients and families, emphasizing the role that interpersonal stressors play in patients' crises, and adopting an active and authentic approach to patients are crucial tools in the evaluation and management of the BPD patient in crisis. Consistent use of these principles can also lead to an increase in the BPD patient's self-reliance and sense of hope. The ED is often viewed simply as a holding chamber or an acute triage setting, but if, by employing these principles, ED staff can approach BPD patients in a caring, informed, and practical manner, the ED can become a forum for meaningful, long-lasting interventions.

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