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Research Article

Experience of Mental Health Professionals with Borderline Personality Disorder: A Qualitative Study

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ABSTRACT

Introduction: The study was conducted to explore the experience of mental health professionals while dealing with or treating Borderline Personality Disorder (BPD) in Pakistan.

Methods: The Qualitative study was conducted through purposive sampling by selecting the professionals having at least 5 years to a maximum of 29 years of experience, working with a borderline personality disorder. Total 18 semi-structured interviews with nine (N=09) psychiatrists and nine (N=09) clinical psychologists were conducted. The analysis was conducted using a framework approach a systematic approach that incorporates both deductive and inductive thematic analysis.

Results: Through the open ended questions professionals explore different concepts such as prevalence and ratio in Pakistan, root causes of BPD in Pakistan, unethical practices, transference and counter transference while dealing with BPD patients, problems faced by professionals for treatment, and explored difference in treatment comparison from the western culture and In Pakistan.

Keywords: Boderline Personality Disorder (BPD), Psychiatrists; Psychologists; Self-harm; Unethical practices

INTRODUCTION

The individuals with Borderline Personality Disorder (BPD) are highly sensitive and fragile in nature, they have an unstable self-image, extremely fluctuating emotions, and impulsive behaviors which often leads to self-destruction[1]. BPD has a lifetime prevalence from 1- 5.9% while the untreated cases have chronic and extreme clinical course. It effects 20% of psychiatric patients and is linked with high health care utilization, therefore, BPD has a substantial socio economic burden [2-6]. BPD is also considered to have high mortality rates up to 10% commit suicide [7,8].In Pakistan it is also a prevalent mental illness with a lifetime prevalence of 18% in general population [9].

Along these lines there are multiple predictive factors associated with BPD as impaired social relations, family conflicts/ adversity, traumatic and stressful events in past, maternal psychopathology or ineffective parenting, exposure to physical and sexual abuse, impulsivity, negative sense of self, neglecting, neuroticism and low levels childhood competence [7,8].Patients diagnosed with BPD suffer intensely but their prognosis is often healthier then perceived and the outcomes can be further improved with suitable treatment choices[10]. Before 2011 some highly specialized psychotherapies started clinical trials for finding the effective treatment of BPD, which has changed the perception of BPD as being untreatable condition. Along with psychotherapies, pharmacology therapy suggested medicine as the best adjunctive for the disorder [11].

Diagnosing BPD is considered to be under recognized and stigmatized in mental health or primary care settings [10,12-17].General Practitioners find their clinical relationship with such patients very challenging and they find their behaviors highly counterproductive for care management [18,19]. Furthermore mental health clinicians maintain an emotional distance from BPD patients in order to protect themselves from patients distressing behaviors [12,20]. Studies from UK, Canada, Australia, Ireland, and Greece showed that generally mental health practitioners have a negative perception for patients diagnosed with BPD in comparison to other mental illnesses [20].

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Living in a collectivistic society professionals working in mental health field are somewhat reluctant, irritable, annoyed and sometimes helpless dealing these emotional people, whether they know the diagnosis but cannot openly label them due to the stigmatization which the patient as well as the family will bear afterwards, therefore the purpose of this study is to explore underlying issues, to identify reasons, risk factors, and attitudes of mental health professionals towards the patients the diagnostic problems and treatment recommendations in the perspective of Pakistan.

METHODOLOGY

This qualitative study involved 18 semi-structured interviews with nine (09) psychiatrists and nine (09) clinical psychologists. The participants have at least 5 years to maximum 29 years of experience of working with borderline personality disorder. The age range was between 30 to 59 years and both genders were involved. The psychiatrists have passed their FCPS exam and Clinical Psychologists have at least done Advanced Diploma in Clinical Psychology which was done after completing their 16 years of education. The mental health professionals were currently working in public and private sectors in Lahore, Karachi, Peshawar, Multan, and Islamabad.

Procedure

Following the ethical process the 12 clinical psychologists and 10 psychiatrists were approached in which 9 clinical psychologists and 9 psychiatrists gave consent for the interview. The purpose of the interview was explained and detailed description of the study was provided, written informed consent was obtained from the willing participants. Participants were assured of confidentiality and anonymity. Semi structured interview was used as a tool to collect data from the participants. The interview was conducted in Urdu language. The duration of an interview ranged from 30-45 minutes on an average. The open ended questions were asked by the researchers related the perception of professionals about BPD, prevalence and ratio in Pakistan, root causes of BPD in Pakistan, unethical practices, transference and counter-transference, problems faced by professionals, recommendations from professionals for treatment and to explore difference in treatment from western culture. The respondents were encouraged to give detailed responses.

Data analysis

Analysis was conducted using a framework approach [21,22]a systematic approach which incorporates both deductive and inductive thematic analysis. The analysis began with reading and re-reading transcripts and reviewing interview notes/ observations. Two authors (first and senior author) independently coded the transcripts and developed an initial coding framework. The framework was altered throughout the coding stage and codes were refined. This process provided a clear and concise overview of the data (Figure 1).

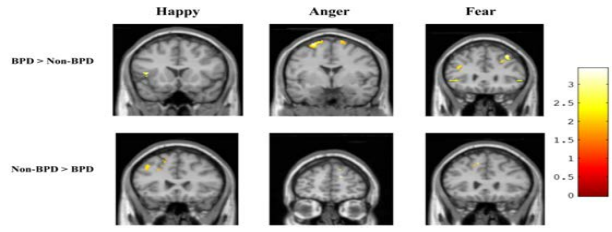

Figure 1: People with BPD showed distinct patterns of activation in the frontal ROI compared to people without BPD, and they tended to show more activation there than people without BPD. BPD, or borderline personality disorder; non-BPD, or no diagnosis.

RESULTS

Different themes have been merged through the framework analysis such as perception about diagnosis of BPD, unethical practices, projective identification, transference, childhood traumas, and lack of awareness, communication issues and stigmatization.

Perception about diagnosis

In Pakistan most of the mental health professionals ignore diagnosing borderline disorder and prefer to diagnose it as borderline personality traits and give it a secondary diagnosis, the primary diagnosis usually is depression. Sometimes the emotional reactions of the patients were taken as histrionic symptom or a feature of bipolar disorder.

- Most of professionals diagnosed BPD as a psychosis" (BPD-Psychiatrist-032).
- Due to emotional instability these patients diagnosed as a bipolar disorder" (BPD-Psychiatrist-042).
- The professionals do not follow DSM-5 neither follow ICD-10 for diagnosis" (BPD-Psychiatrist-046).
- There is no accountability of professionals for the diagnosis of Bipolar disorder (BPD-Psychiatrist-49).
- Professionals prefer to diagnose the patients initially on axis 2 as NOS (not otherwise specified). DSM 5 also offered this as a trait (BPD-CP -65)

Underlying reasons of BPD

There are different underlying reasons which explore during the semi structured interview from the professionals both psychiatrist and clinical psychologists these are:

- These symptoms occur due to the traumatic event in the childhood (BPD-Psychiatrist-162).
- Patients suffer any abusive relationship (the abuse could be physical, verbal, sexual or emotional) which could develops these symptoms (BPD-CP-11).
- Emotional neglect and fear of abandonment (BPD- CP-177).
- These individuals seek attention by cutting or harming themselves (BPD-Psychiatrist- 26).

- The patients feel pleasure by harming themselves or feel relief from own emotions through self- injurious behavior (BPD-Psychiatrist-189).
- These symptoms are the result of authoritative parenting (BPD-Psychiatrist-201).
- The single parenting either father or mother is also become the cause of BPD symptoms (BPD-Psychiatrist-59).
- Lack of stress coping skills are another reason to develop these symptoms (BPD- CP-88).
- Poor communication skills is the main underlying reason among borderline patients (BPD-CP-111).
- Often in these patients a non-verbal gesture for self-harm has been observed which is 'cry" as they don't know how to communicate verbally (BPD-CP-171)
- The emotional pain is so intense for them that the easier way of diversion is physical pain therefore they try to inflict pain to get relief from the emotional state (BPD-CP-576)

Ratio/ Prevalence of BPD symptoms

According to many mental health professionals, females show more symptoms of borderline personality as compared to males, there are some verbatim of the professionals.

- Women suffer more due to BPD symptoms ((BPD-Psychiatrist-31).
- The most cases reported in the female patients as they are more sensitive by nature and more overtly emotional (BPD-Psychiatrist-19).
- Females are insecure by nature and that is very much prevalent in their behavior as they show more instability of emotions and self-destructive behavior (BPD-CP-66).
- Unfortunately females can only get attention by showing somatic symptoms not only in our society but in western culture too, when they try to express themselves cognitively no one usually take them seriously considering them as an emotional being therefore this extreme emotional impulse and apparent behavior occur more in female to prove their existence and to show that yes they can also feel and get hurt (BPD-CP-343)
- Females are born with an instinct of manipulation and confusion that is why the extremism and mood swings of borderline type are very common in them (BPD-Psychiatrist-84).
- We find huge reporting with these symptoms in clinical setting (BPD-Psychiatrist-89).

Unethical practices

Due to the lack of supervision and proper mentorship, the unethical practices are also frequent in our clinical settings and unfortunately there is no accountability.

- Many professionals seem to involve in unethical practices with patients mostly when the mental health professional is of opposite gender (BPD-Psychiatrist-74).
- Sometimes doctors and therapists take undue sessions for monitory gains (BPD-Psychiatrist-402).
- Some practitioners misuse the patient's emotional problem" (BPD-CP-12).
- They are often unable to deal with the patient due to lack of clinical practice" (BPD-CP-101).
- Most therapists take gifts or charge more fee from the needy, helpless clients (BPD-CP-204).

Projective identification

Most of the professionals often project the feelings of patients as the patient overgeneralized the symptoms and manipulate their situations in front of the clinicians. This is the trap through which all the doctors must be aware.

- Patients consider that the practitioner also have the same feelings as him/ her (BPD-CP-143).
- Patients manipulate their problem in front of therapist/ practitioner (BPD-Psychiatrist-67).

Transference/ counter transference

While dealing with the patients especially in the opposite gender transference is the very important phenomenon of in our culture and in psychology and psychiatry.

- BPD patients often develop transference towards the therapist (BPD-CP-198).
- They take the therapist as the problem solver and sometimes their fluctuation on mood shatter the trust too, where they have transference towards the therapist there they could develop negative transference too at same pace (BPD-CP-377).
- BPD patients plays with lot of tactics with doctor to distract them (BPD-Psychiatrist-98).
- These patients manipulate the situation and symptoms (BPD-Psychiatrist-124).
- The patients often check the credibility of doctors by exaggerating their symptoms (BPD-Psychiatrist-116).
- Due to opposite gender between professional and patient, this is happened in the most of the cases (BPD-CP-29).

Problems faced by professionals

The feelings of distress, irritability, fatigue, avoidance and exhaustion is faced by professionals while dealing with these emotionally swirling people.

- Professionals often receive threat from these patients e.g. gun point threat, self-harm tendencies (BPD-Psychiatrist-53).
- Sometimes due to lack of competence professionals easily come in the trap of their manipulation (BPD-Psychiatrist-99).
- The patients and their family having lack of awareness blamed the therapist (BPD-CP-75).
- Patients usually consult from doctor when the symptoms are very severe and at peak level (BPD-CP-101).
- Crisis management is difficult as most of the clinical psychologists are females and the untimely calls of these clients disturb their family life (BPD-CP-465)
- Care givers pressurize the doctors for abrupt recovery and wanted them to do as they say and persuade the patient to follow parents/ family rules (BPD-Psychiatrist-199).
- Doctors often feel burden while dealing with these patients (BPD-Psychiatrist-28).

- The professionals usually felt burn out while dealing with these patients (BPD-Psychiatrist-446).
- Professional feel irritability, fatigued, manipulated, humiliated, and discouraged while treating BPD (BPD-Psychiatrist-662).

Recomendations for treatment

There are some recommendations of the treatment which somehow all the mental health professionals suggest working in these guidelines.

- Awareness must be raised about the personality problems (BPD-CP-199).
- Systematic approach must be used for their treatment (BPD-CP-189).
- Only medication is not the solution to resolve the symptoms (BPD-Psychiatrist-201).
- Myth in our society about mental health problem must be resolved, all problems can be dealt (BPD-Psychiatrist-289).
- Psychotherapy is essential with the medication/ without medication depends on the intensity of the symptoms (BPD-CP-284).
- Adaptation and knowledge about new approaches of psychotherapy should be utilized here and professionals should get training/ knowledge about the updated treatments for this beautifully emotional population (BPD-Psychiatrist-722).
- Crisis management must be in their management plan (BPD-CP-179).
- Family education must be involved in their treatment plan (BPD-CP-177).
- New treatments like metallization, Dialectical Behaviour Therapy, Acceptance Commitment Therapy and Schema focused Therapy should be introduced in Pakistan so that the experienced Clinical Psychologists should get training in it to benefit their clients (BPD-CP-243)
- There should be rule passed through the authorities that novice therapists/ Practionner should not
- deal this sensitive population. If they have to then they should give consultation under supervision of any experienced therapist as this population is very much vulnerable and we should show some responsibility towards them (BPD-CP-393)

Difference in treatment from Western culture

- In Pakistan, patients consult psychiatrist when the symptoms will be out of control (BPD-CP-211).
- Psychiatrists are reluctant to refer patients to clinical psychologists whether the patient is in dire need of a therapist to help them (BPD-Psychiatrist-378).
- Stigmatization is the main problem in Pakistan (BPD- CP-84).
- In west, proper detailed assessment was done, there are many center to deal crises and borderline personality people and suicidal people but in Pakistan we do not have any crises management centers which psychologically and emotionally cadre these patients in emergency, the emergencies of teaching hospitals, private hospitals, drug rehab centers and psychiatrists deal these emotional people in the outdoor departments therefore these vulnerable souls were not given proper time and attention (BPD-CP- 222).

DISCUSSION

The current study explored the experiences of mental health professionals with patients of borderline personality disorder (BPD). The study presented various themes which demonstrated the attitudes and opinions of mental health practitioners towards borderline personality disorder. Regarding perception of the diagnosis of BPD most of the mental health professionals stated in their interviews that they usually try not to give BPD as a primary diagnosis. It goes under personality traits or as secondary diagnosis stating depression or bipolar or psychosis as a primary diagnosis. Qualitative explorations about unethical practices also revealed that due to no accountability and proper supervision use of unethical practices is very common unfortunately. Monetary gain and lack of clinical practices are also observed. Another key finding from the theme derivation was projective identification. Most of them reported that patients with BPD tries to manipulate the practitioner or sometimes overgeneralize their symptomatology in order to gain the sympathies. Patients also thinks that their practitioner feels the same problems and this projective identification can be noted both ways. A whole lot of negative statements were seen when the mental health practitioners talked about the transference and counter transference. They openly suggested that patients with BPD tries to check the credibility and skills of the practitioners so they use a lot of tactics and manipulation while describing their symptoms and those are generally not a part of their problem. Role of gender is also important when it comes to transference as empathy from the practitioner can easily be judged as sympathy and vice versa. It was also reported that due to the unstable attitude of the patients sometimes professionals are unable to tolerate them. Although this should not happen but professionals are also humans and at times lose their patience due to feelings of distress, irritability, or fatigue [23].

CONCLUSION

The practitioners usually feel burn out while dealing with BPD patients. Sometimes the manipulations from such patients work as a key to burn out and sometimes their families who want an abrupt change plays the key role in making the practitioner burdened. From the themes it can be seen clearly that the practitioners also become biased when it comes to diagnosing and dealing with the BPD patients. Suggested that typically the diagnostic label of BPD referred as a Difficult Patient, precisely that is why we are in dire need of adaptation of new systematic approaches of treating BPD. With reference to Pakistan a lot of things needs to be addressed in which stigmatization and awareness of such disorder is the foremost. The current study tries to give a jest of what our practitioners think so that future studies can gain the benefit and demonstrate some good procedures to implement and follow.

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