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. 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.

When seen in the health care setting, patients with BPD are often a challenge to provider organizations. 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.

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. It may also influence how patients respond to specific clinical situations, such as insulin-induced hypoglycemia.

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>
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<th>Table 1. Coping Characteristics and Symptom Complexes in BPD</th>
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<td><strong>Coping Characteristics</strong></td>
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<tr>
<td>• Splitting behavior</td>
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<td>• Sabotaging behavior</td>
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<td>• Victim-rescuer relationships</td>
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<td><strong>Symptom Complexes</strong></td>
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<td>• Impulsive and self-destructive behavior</td>
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<td>• Rapid mood swings with anxiety and depression</td>
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<td>• Feelings of boredom and isolation</td>
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<td>• Intense and unstable personal relationships</td>
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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 her husband’s fault. “I asked him to go get me a meter,” she claims, “But he refused.” The physician asks when she was accompanied by 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.

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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 dissatisfaction 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.

REFERENCES


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