Factors Associated with Emergency Department Patients' Knowledge of Their Borderline Personality Disorder Diagnosis

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Short Report

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Abstract

Background

Research on borderline personality disorder (BDP) has shown that less intensive, easier-to-learn approaches like good psychiatric management (GPM) are especially effective when based on patient knowledge of their diagnosis and the provision of psychoeducation. However, issues with failing to make the diagnosis are also described in the literature. This study therefore aimed to explore the sociodemographic and clinical factors associated with the challenges of detecting BDP and providing a diagnosis to patients.

Methods

A retrospective database maintained at Toulouse University Hospital was employed in the study. This contains information on 202 patients with a CIM -10 F60.3 diagnosis admitted to the short-term hospitalization unit of the adult psychiatric emergency department (ED). This data was used to compare the sociodemographic and clinical benchmarks associated with knowledge of the criteria employed for diagnosing BDP. We then performed a multimodal logistic regression analysis.

Findings

We found that 63% of the BDP patients in the database were aware of their diagnosis. The regression model identified that the factors associated with this knowledge were: a history of hospitalization on a psychiatric ward (OR=6.1; 95% CI= [2.3-17]); having a major depressive disorder (MDD) diagnosis (OR=0.4; 95% CI= [0.1-0.9]); and the number of admissions to the ED in the previous 12 months (OR=1.25; 95% CI= [1.02-1.5]).

Conclusions

The main factor associated with knowledge of a BDP diagnosis was previous hospitalization on a psychiatric ward, suggesting a lack of disclosure in outpatient care. This could mean that incorporating a period of short-term hospitalization (as occurs in the ED) in the healthcare provided could not only improve how physicians detect the disorder, but also their delivery of the diagnosis to patients.

Background

Borderline personality disorderis characterized in DSM-5 by the impairment and pervasive dysregulation of affects, self-image, interpersonal relationships, and behavior (1). Recently, the prognosis has changed from untreatable to treatable with multiple evidence-based psychotherapies (2)(3). In addition, recent research has shown that less intensive, easier-to-learn therapies may be almost as effective such as GPM approach developed by Gunderson (4). It is now recommended as the primary intervention and, as part of this, it is essential to provide information about the diagnosis and relevant psychological training. Nonetheless, a failure to detect and diagnose BDP is commonly described in the literature. An example is

a survey carried out among a psychiatric population which found that 57% of psychiatrists failed to identify BPD and 37% did not document it in patients' records (5). In fact, the diagnosis can be difficult to make, as patients with BPD frequently consult physicians about other issues (somatic complaints, depressive symptoms, substance use) (4), potentially leading to alternative diagnoses (6). Nevertheless, making and communicating a BDP diagnosis is critical, indeed, it enables: therapeutic follow-ups to be put in place; expectations to be managed; symptoms to be distinguished from voluntary behaviors; the anticipation of emergencies and crises and the avoidance of negative reactions.

A stronghold for BPD healthcare is the ED (7,8), which is both a key element in providing continuity of care and a venue for crisis management (10). In addition, patients suffering from BPD are an important cohort for EDs, accounting for 9% of overall attendances (9). Consequently, those attendees who already have a BPD diagnosis may be a valuable resource, as they represent a wide spectrum of patient profiles (e.g., those with or without a care plan, and patients with or without comorbidities).

This study aims to improve what is understood of why patients are unaware of their BPD diagnosis in a cohort of patients admitted for short-term hospitalization in the ED of Toulouse University Hospital.

Methods

Population

We performed a retrospective study involving the ED of Toulouse University Hospital (France) during the period 1.1.20–7.31.21. Our inclusion criteria were as follows: patients admitted for short-term hospitalization on the ward of the adult psychiatric ED; either sex; aged 15 or older, with no upper age limit; and a CIM – 10 F60.3 primary or secondary diagnosis, as recorded in our database (Orbis® software).

Data

The following information was obtained from the medical files:

- Sociodemographic data: age, gender, level of education, professional status, personal status.
- Clinical data: reason for admission to the ED, any diagnosis associated with a BPD diagnosis, an addiction diagnosis associated with a BPD diagnosis, current follow-ups with a general physician, current psychiatric follow-ups, history of attempted suicide, and number of admissions to the ED in the previous 12 months.
- For all the patients admitted to the short-term hospitalization ward: their knowledge of their psychiatric diagnosis. If a patient indicated an awareness of their BPD status, he/she was assigned to a known-diagnosis group; otherwise, patients were placed in an unknown-diagnosis cohort.

Ethics

Our use of the data was approved by the Commission Nationale de l'Information et des Libertés (CNIL), according to the French legislation: MR-004.

Statistical analysis

The continuous and categorical variables are described in the paper using the mean (+/- standard deviation) and/or the median (+/- interquartile range), based on their distributions and numbers and percentages, respectively. Associations between the patients' categorical characteristics and their diagnosis knowledge were tested using the chi-squared or Fischer exact tests (when the expected values were less than 5.0). A multivariable logistic regression model was employed to assess any link between the sociodemographic and clinical characteristics and knowledge of the BDP diagnosis, or the absence thereof. The variables found to be significantly associated in the $p < 0.05$ bivariate analyses were included in the initial regression model, along with the potential confounding factor of diagnosis awareness. We then performed a backwards, step-by-step manual selection to produce our final model, controlling for confounding variables at each stage. The statistical analyses were performed using the RStudio software, version 1.3.1093©, 2009–2020.

Results

General description of the population

Two hundred and two patients were included in the analysis. Of this cohort, 43% were admitted to the ED for suicidal ideation, 37% for a suicide attempt, 5.5% for alcohol or other narcotic intoxication, 8% for non-psychiatric reasons (various somatic complaints), 5% for anxiety and 1.5% for depressive symptoms.

Comparative analysis based on knowledge of a BPD diagnosis

One hundred and twenty-eight patients (63%) were aware of their BPD diagnosis. Those in this cohort were more likely to: be employed (55% versus 35% in the unknown diagnosis group; $p = 0.01$); have a psychiatric follow-up in place (77% versus 55%; $p < 0.001$); have already been hospitalized on a psychiatric ward (85% versus 44%; $p < 0.001$); have a history of a suicide attempt (80% versus 52%; $p < 0.001$); and have a higher number of ED admissions in the previous 12 months (0.97 admissions on average versus an average of 2.7; $p < 0.001$). Conversely, the patients who were unaware of their BDP diagnosis were more likely to have received a diagnosis of MDD (41% in the unknown diagnosis group versus 26% in the knowledge of diagnosis cohort; $p < 0.001$). The details of the comparisons are presented in Table 1.

Table 1

Comparison between sociodemographic and clinical characteristics based on knowledge of a BPD diagnosis. Pers. status: personal status; gen. practitioner: general practitioner; psy follow up: psychiatric follow up; comorb. psy: comorbidities of psychiatric disorders; comorb. addiction: comorbidities of addiction; prev hosp. psychiatry: previous hospitalization in psychiatry; past hist. psy. in family: past history of psychiatric disorder in the family; number of ED consults. in the prev. 12 months: number of emergency department consultations in the previous 12 months.

Characteristics n (%) or mean (SD)	**Known diagnosis (n (%)) n = 128 (63)**	**Unknown diagnosis (n (%)) n = 74 (37)**	**p value**
Age (years)			
15–25	70 (55)	48 (65)	0.6
26–35	35 (27)	13 (18)	
36–45	10 (8)	4 (5)	
46–55	9 (7)	7 (9)	
56–65	3 (2)	1 (1)	
Over 65	1 (0.7)	1 (1)	
Level of education			
Less than high school	33 (25)	19 (25)	0.5
High school	23 (18)	12 (16)	
More than high school	72 (56)	43 (58)	
Gender	92 (70)	51 (68)	0.6
Pro. status			
Employed	71 (55)	26 (35)	**0.01**
Unemployed	24 (19)	21 (28)	
Student	33 (26)	27 (36)	
Pers. status			
Single	87 (68)	47 (63)	0.3
Attached	36 (28)	22 (30)	
Divorced	5 (4)	4 (5)	
Widow/widower	0 (0)	1 (1)	

Characteristics n (%) or mean (SD)	Known diagnosis (n (%)) n = 128 (63)	Unknown diagnosis (n (%)) n = 74 (37)	p value
Gen. practitioner (yes)	108 (84)	58 (78)	0.2
Psy. follow up	99	38	**< 0.001**
Comorb. psychiatry	70 (55)	41(55)	0.5
MDD	34 (26)	31 (41)	**< 0.001**
BD	15 (12)	7 (9)	0.5
ED	21 (16)	10 (14)	0.2
ADHD	4 (3)	3 (4)	0.9
SCZ	7 (5)	2 (3)	0.4
PTSD	3 (2)	3 (4)	0.5
Comorb. addiction	25 (19)	14 (18)	0.9
Alcohol	11 (9)	8 (11)	0.6
Tobacco	16 (13)	10 (13)	0.4
Cannabis	15 (12)	8 (11)	0.7
Other	17 (13)	7 (9)	0.6
Prev. hosp. psychiatry	109 (85)	33 (44)	**< 0.001**
Past hist. suicide attempt	101 (80)	39 (52)	**< 0.001**
Past hist. psy. in family	120 (94)	70 (93)	0.8
Numb of ED consults. in the prev. 12 months	0.97 (1.5)	2.7 (2.8)	**< 0.001**

Multivariable logistic regression

Three factors were identified as having an association with knowledge of a BPD diagnosis: a history of hospitalization on a psychiatric ward (OR = 6.1; 95% CI= [2.3–17]); an MDD diagnosis (OR = 0.4; 95% CI= [0.1–0.9]); and the number of admissions to the ED in the previous 12 months (OR = 1.25; 95% CI= [1.02–1.5]). There were no significant links between diagnosis knowledge and having a psychiatric follow up in place, a history of suicide attempts, or the patient's professional status.

The results of this regression analysis are represented in Fig. 1.

Discussion

Knowledge of their BPD diagnosis is a crucial part of the care patients receive. Our study therefore used a population of those suffering from the disorder to investigate the factors associated with why some among this cohort were unaware that they had been diagnosed with the condition.

Of the patients in our research, 37% were unaware of their BPD diagnosis. Those with the disorder were mainly admitted to the ED due to a suicidal crisis, as reflected in the existing literature (11,12). Moreover, comorbidities were present in a large number of patients: 55% had an additional psychiatric diagnosis and about 20% an addiction, as is also commonly described in the literature (13,14).

The analysis identified that the patients who were aware of their BPD diagnosis were six times more likely to have been hospitalized on our psychiatric ward. This finding is striking, as treatment guidelines recommend that these patients should, as far as possible, not be hospitalized. We hypothesized that improved clinical observations during a period of hospitalization enable the diagnosis to be established. As we did not identify an association between having a psychiatric follow up in place and knowledge of a BPD diagnosis, it may be that clinicians are more confident about delivering this information during inpatient care. Indeed, it has been reported elsewhere that psychiatrists experience greater discomfort about disclosing a BDP diagnosis to patients than is the case with other psychiatric conditions (5). This is despite both the sense of relief described by patients and their relatives when the diagnosis is disclosed (15), and the availability of questionnaires that aim to assist clinicians to detect the disorder (16,17).

We also found that the number of ED admissions was associated with knowledge of the BPD diagnosis, which may be due to delays in diagnosing the condition or only doing so for patients presenting with the most severe symptoms.

Our research has some limitations, especially its retrospective design and absence of new data collection and its cross-sectional design, which only enabled us to identify associations and not test the explicative hypotheses.

Moreover, patients diagnosed with MDD were less likely to know that clinicians had identified that they also suffered from BPD. Previous studies have certainly highlighted that such a diagnosis can be difficult to establish and may be confused with other conditions (18).

In conclusion, the main factor associated with knowledge of a BPD diagnosis among our population was a previous admission to a psychiatric ward, suggesting a lack of disclosure during outpatient care. This observation identifies the possible use of the ED as a location for improving the detection of BDP, since a brief period of hospitalization could be proposed by clinicians in this department. Even though the guidelines recommend that inpatient treatment should be avoided, a stepped care intervention that includes short-term hospitalization could be a valuable ED tool. In particular, this would not only enable more detailed safety and care plans to be put in place, but also improved relationships with relatives (19).

It would also give clinicians more time to make an evaluation and is a secure environment for imparting the diagnosis. This could be exploited in a stepped care approach, which has previously been modelized for BPD (20–22), and could reduce the need for future, and longer, periods of hospitalization.

Abbreviations

BPD
Borderline personality disorder
CIM
Classification internationale des maladies
ED
Emergency department
MDD
Major depressive disorder
OR
Odds ratio

Declarations

Availability of data and materials

The datasets used during the study are available from the corresponding author on reasonable request.

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Contributions

JS and MA wrote the article; EB, MA and JS designed the study; MA collected the data; JS performed the statistical analysis.

Ethics approval and consent to participation

This study was performed in line with the principles of the Declaration of Helsinki and was approved by the Regional Ethics Committee in Uppsala (Ref. no. 2014/252). Written informed consent was obtained from all the individual participants included in the study.

Consent for publication

The patients in the study have given their signed, informed consent regarding the publication of their data.

Competing interests

None of the authors have any conflicts of interest to declare.

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Figures

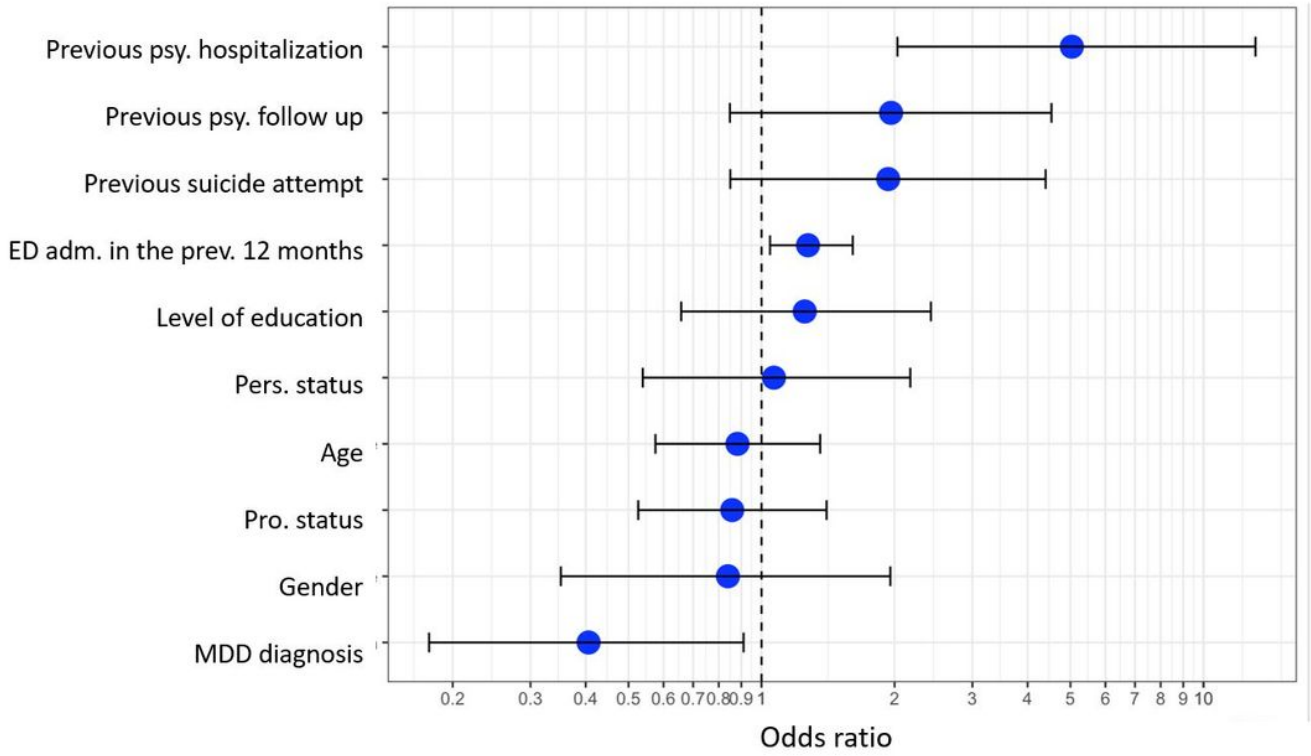

Figure 1

Multimodal regression analysis. Previous psy. hospitalization: previous psychiatric hospitalization; previous psy follow up: previous psychiatric follow up; ED adm. in the previous 12 months: ED admission in the previous 12 months; pro. status: professional status; MDD diagnosis: major depressive disorder diagnosis.