Borderline Personality Disorder

BPD

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PSX_003 Counselling Psychology
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What is Borderline Personality Disorder?

– By Illustrator Shawn Coss –

Definition

Serious mental disorder

Instability in

- Moods
- Behaviour
- Self-image
- Functioning

→ Impulsive actions

→ Unstable relationships

Episodes of anger, depression, and anxiety (from a few hours to days)

Criteria

Borderline Personality Disorder (BPD) (301.83)

DSM-5 (American Psychiatric Association, 2013)

Indicated by five (or more) of the following:

1. Avoid real or imagined abandonment
2. Unstable and intense relationships
3. Identity disturbance
4. Impulsivity in at two areas that are self-damaging
5. Suicidal behaviour, gestures, or threats, or self-mutilating behavior
6. Affective instability
7. Chronic feelings of emptiness.
8. Anger
9. Paranoid ideation

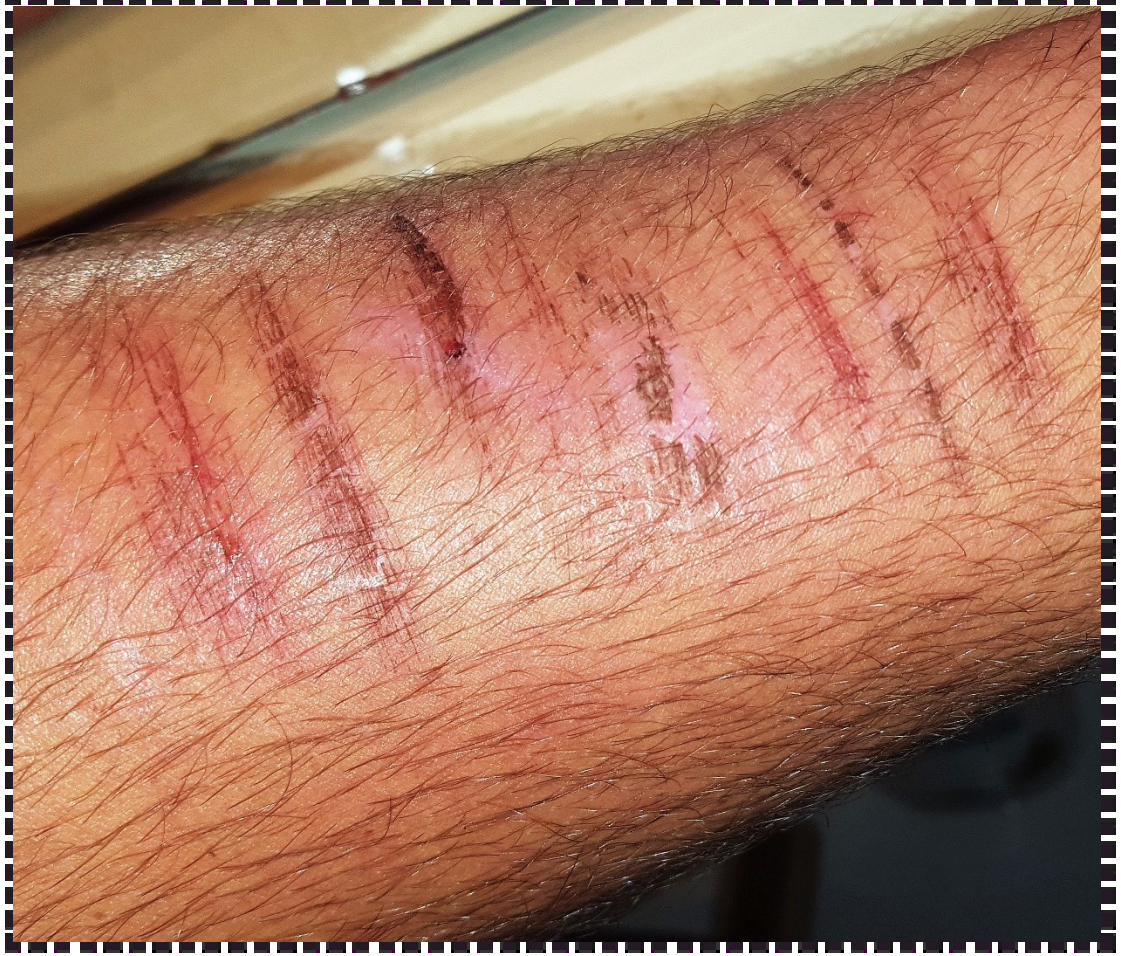
Beginning by early adulthood

Associated features

- **Give up goals**
- **More secure with transitional objects**
- **Psychotic Symptoms**
- **Job losses, interrumpted education, separation/divorce**

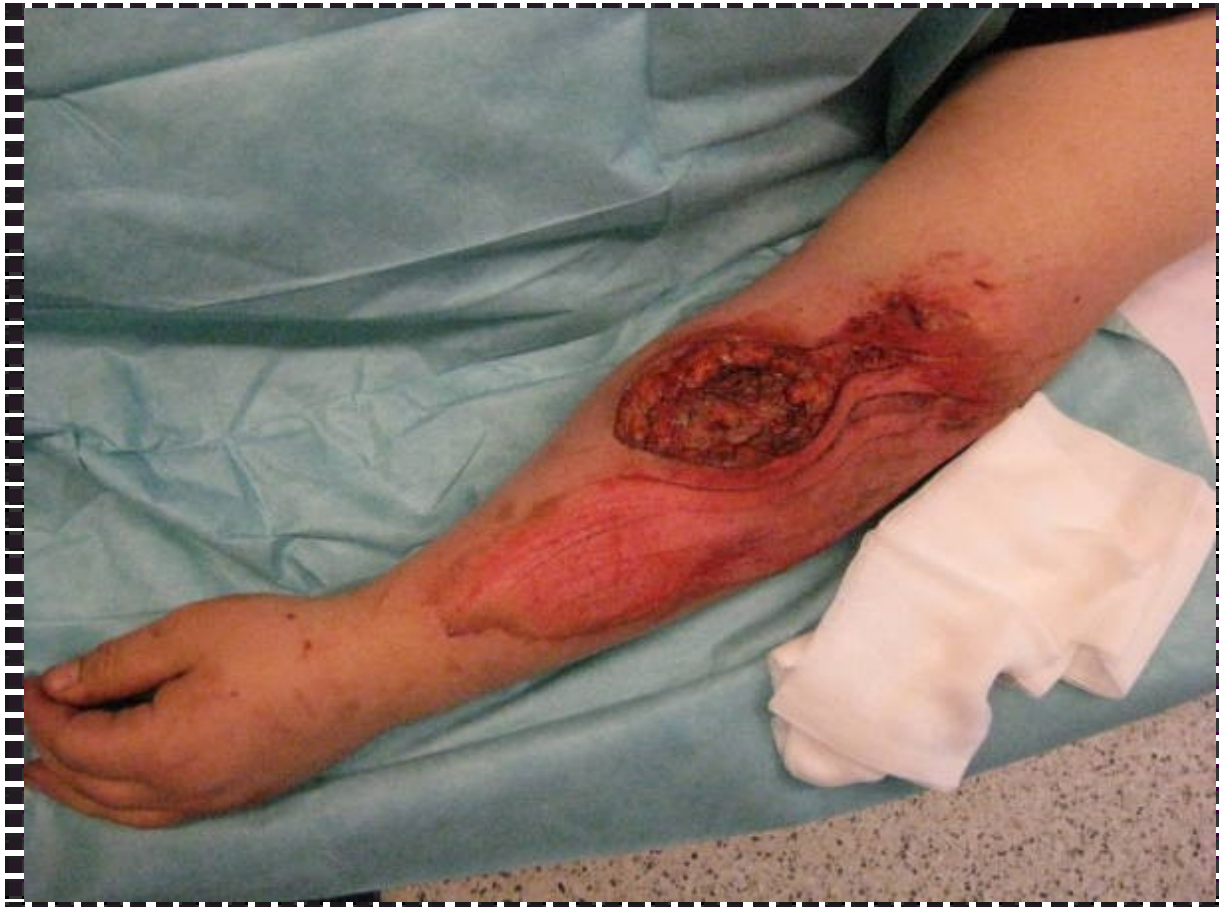
Different states of wound healing

Self-damaging



Self-damaging

Secondary wound healing in a psychiatric BPD patient after self-mutilation



Criteria

Emotionally unstable personality disorder (F60.3)

ICD-10 (World Health Organization, 1992)

A. F60.30 Impulsive type (3 of them must be present, including "2")

1. Act unexpectedly and without consideration of the consequences.
2. Engage in quarrelsome behaviour and to have conflicts with others.
3. Outbursts of anger or violence.
4. Difficulty in maintaining any course of action that offers no immediate reward.
5. Unstable and capricious mood.

B. F60.31 Borderline type (≥ 3 of Impulsive type must be present and two of the following):

1. Disturbances in and uncertainty about self-image, aims, and internal preferences.
2. Liability to become involved in intense and unstable relationships.
3. Excessive efforts to avoid abandonment.
4. Recurrent threats or acts of self-harm.
5. Chronic feelings of emptiness.
6. Demonstrates impulsive behaviour.

Development and Course

- **Considerably variable course**
- **Instability in early adulthood**
- **Severe affective and impulsive dyscontrol**
- **High levels of use of health and mental health resources**

More impairment for the disorder and risk of suicide in young-adult years

Decreases with age

30s-40s

↓

Greater stability in their relationships and vocational functioning

Development and Course

Less stable over time than expected

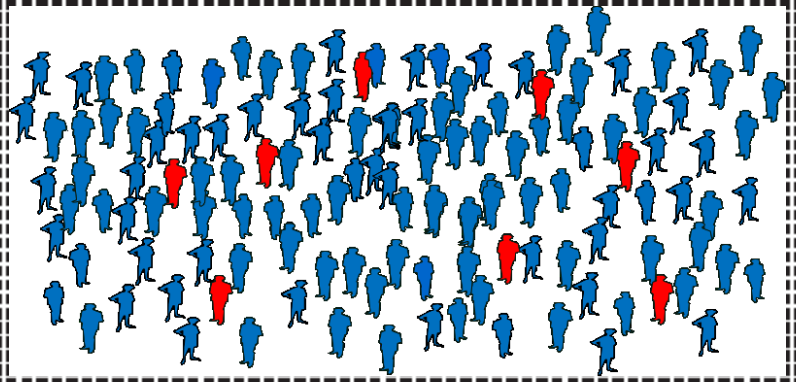
(Skodol et al., 2005; Lenzenweger et al., 2007; Gunderson et al., 2003)

Lifelong tendency toward intense emotions, impulsivity, and intensity in relationships but

Improvement in the first year of therapeutic intervention

Prevalence

DSM-5 (American Psychiatric Association, 2013)



Average population	**Between 1.6% and 5.9%**
Predominantly in females	about 75%
Primary care settings	about 6%
Outpatient mental health clinics	about 10%
Psychiatric inpatients	about 20%

Etiology

GENETIC AND BRAIN FACTORS

+

ENVIRONMENTAL FACTORS

→

GxE

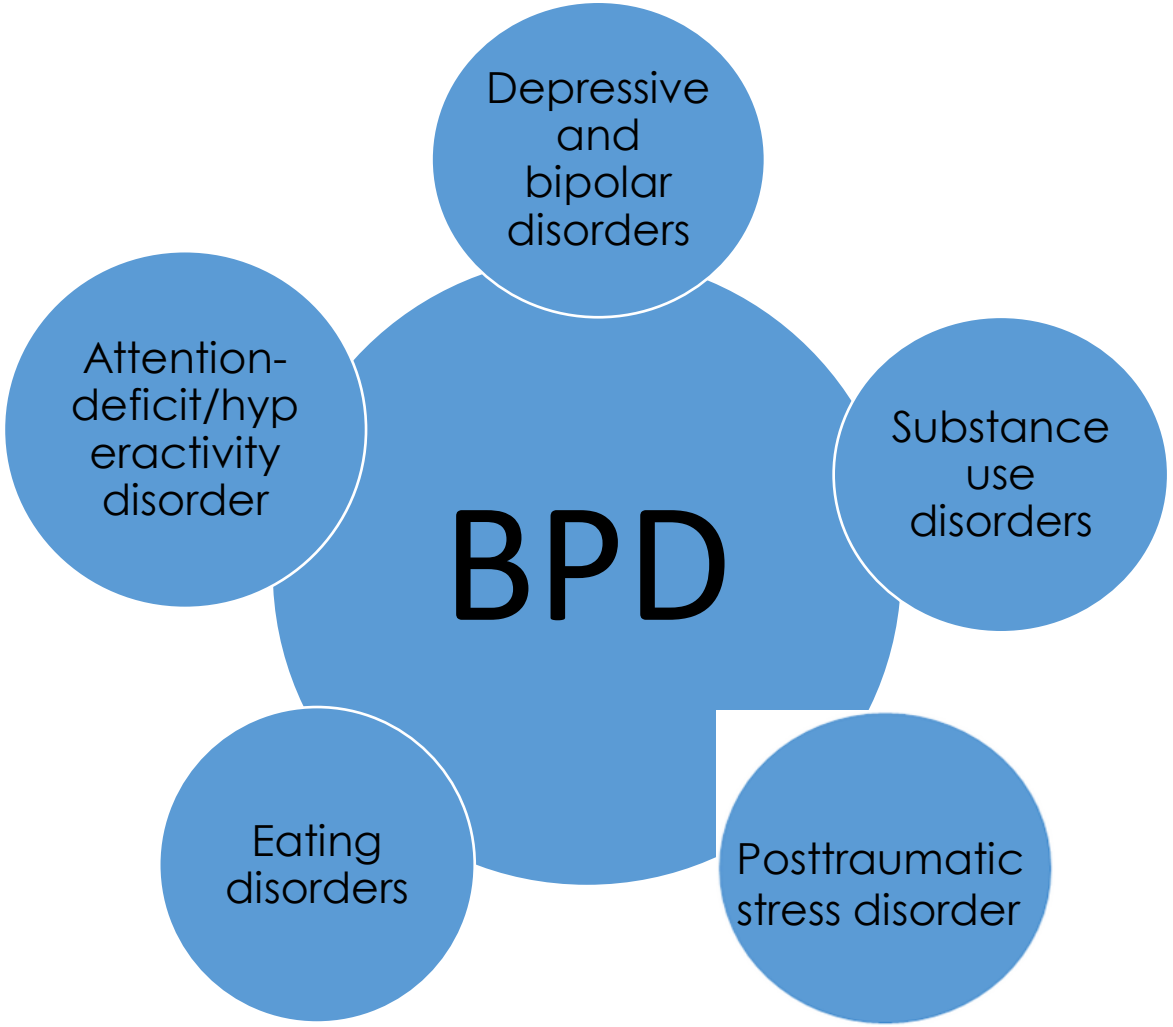
Diagnosis

- Underdiagnosed or misdiagnosed
- Symptoms that overlap with BPD → difficult to distinguish BPD

  I.e.: a person may describe feelings of depression but may not bring other symptoms to the mental health professional's attention (National Institute of Mental Health, 2016).

- Relief when people with BPD realize that others understand their experience and treatment options exist

Differential Diagnosis



DSM-5 (American Psychiatric Association, 2013)

Differential Diagnosis

BPD

≠

Personality change

BPD

≠

Symptoms in association with persistent substance use

BPD

≠

Identity problem

Impact on functioning

FAMILY

- BPD can feel angry at members of their family
- Family members feel angry and helpless
- Parents of BPD patient can have a bad behavior → overinvolvement (i.e.incest) or underinvolvement

ROMANTIC RELATIONSHIP

- High levels of chronic stress and conflict
- Decrease satisfaction of romantic partners
- Abuse
- Unwanted pregnancy

Impact on functioning

Splitting - Idealization and Devaluation

- Major **defense mechanism** of BPD patients
- 'All-good' or 'All-bad'- ~~Middle ground~~
- Idealization = splite white
- Devaltuation = splite black

"Dichotomous thinking"

(Beck and Freeman)

"All or none thinking"

(Linehan)

Psychotherapy → Shades of grey

Impact on functioning

Psychopathology in the extended families of BPD

Davidson and Siever (1991)	• Higher risks for affective and impulse disorders
Goldman, D'Angelo & De Maso (1993)	• Greater rates of depression • Substance abuse • Antisocial characteristics
Zanarini (2004)	• The families of BPD probands were more likely to have BPD psychopathology compared with the non BPD probands

Impact of functioning

Psychopathology in the parents of BPD patients

Studies with both parents	Studies with mother	Studies with father
• **Uncaring and overcontrolling** Zweig-Frank , Paris J., 1997; Weaver, Clum, 1993; Parker, Roy, Wilhelm et al. (1999)	• **Insecure attachment** • **The perception of a lack of caring** Nickell et al. (2002)	• **Not too many studies about fathers** • **Negative image** Baker et al. (1992)
• **Unempathetic** Guttman, Laporte, 2000	• **Egocentric** Golomb, Ludolph & Westen (1994)	↓
• **Conflictual** Allen, Abramson, Whitson et al., 2005	• **Overinvolved** Liotti & Pasquini, 2000	• Age • Perpetrators of sexual abuse
• **Less affectionate** Johnson, Cohen, Chen, et al., 2006		
• **Over-involved / under involved** Allen & Farmer, 1996		
• **More unfavorable in all aspects** Bandelow et al. (2005)	→	Unflattering light

Children of mothers with BPD

- Less available for positive engagement
- Disorganized
- Insensitive

Hobson and colleagues (2005)

- Lower self-esteem
- Exhibited more emotional and behavioral problems
- More harm avoidant

Barnow and colleagues (2006)

- More impulsive
- More psychiatric diagnoses
- Higher prevalence

Weiss et al. (1996)

- Less sensitive with offspring
- Children had less desire to interact, less satisfied, less competent and more distressed

Newman et al. (2007)

Treatment and Therapies

D and their relatives, couple, friends and
receive appropriate support during
l Health, 2016).

Psychotherapy is the primary treatment

Medication is useful for treating comorbid disorders

Short-term hospitalization is not more effective than community care for improving outcomes or long-term prevention of suicidal behavior (Paris, 2004)

Medication

A systematic review and meta-analysis of randomised controlled trials (RCT)

Impact isolated symptoms of BPD or the symptoms of comorbid conditions

Antipsychotics

Mood stabilizers

Antidepressants

RESULTS

Haloperidol → anger
Flupenthixol → likelihood of suicidal behaviour
Aripiprazole → interpersonal problems and impulsivity.
Olanzapine → affective instability, anger, psychotic paranoid symptoms, and anxiety
Ziprasidone → not significant.

★ Placebo had a greater ameliorative impact on suicidal ideation than olanzapine did

Valproate semisodium → depression, interpersonal problems, and anger
Lamotrigine → impulsivity and anger;
Topiramate → interpersonal problems, impulsivity, anxiety, anger, and general psychiatric pathology
Carbamazepine → not significant.
Amitriptyline → depression

Mianserin, ***fluoxetine***, ***fluvoxamine***, and ***phenelzine sulfate*** → no effect.
Omega-3 fatty acid → less suicidality and improve depression

★ From 2010, trials with these medications have not been replicated and the effect of long-term use have not been assessed.

Cochrane collaboration (Stoffers et al., 2010)

Medication

Serious side effects from some of these medications

Medication should not be used specifically for BPD and its individual symptoms or associated behaviou0r

(UK National Institute for Health and Clinical Excellence, 2009)

Considered in the general treatment of comorbid conditions

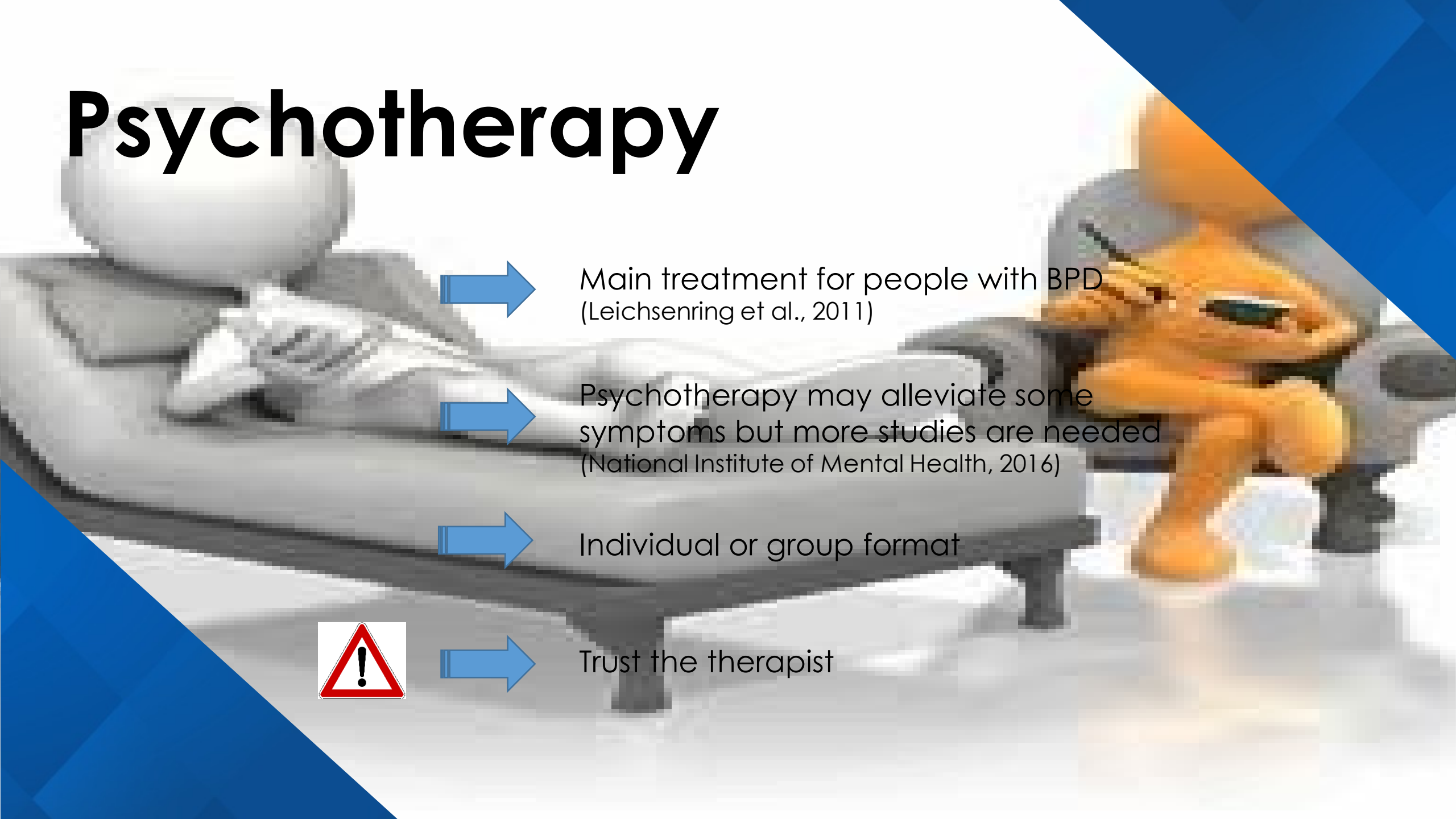
Medication

Which medications improve which BPD symptoms?

Medication	Symptom domain	Effect
Antipsychotics	Cognitive-perceptual	Moderate
	Anger	Moderate/large
Antidepressants	Anxiety	Small
	Anger	Small
Mood stabilizers	Impulsive-behavioral dyscontrol	Very large
	Anger	Very large
	Anxiety	Large
	Depressed mood	Moderate

Ingenhoven, Lafay, Rinne et al. (2010)

Psychotherapy



- Main treatment for people with BPD
  (Leichsenring et al., 2011)
- Psychotherapy may alleviate some symptoms but more studies are needed
  (National Institute of Mental Health, 2016)
- Individual or group format
- Trust the therapist

Cognitive Behavioural Therapy

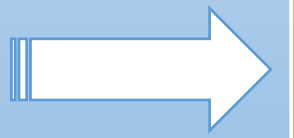
(CBT)

Identify and change beliefs and/or behaviours that cause inaccurate perceptions of themselves & others

Observable behaviours

Psychic schemata or "inner scripts"

BPD: Maladaptative shemata and behaviours



Dichotomous thinking
(Beck & Freeman, 1990)

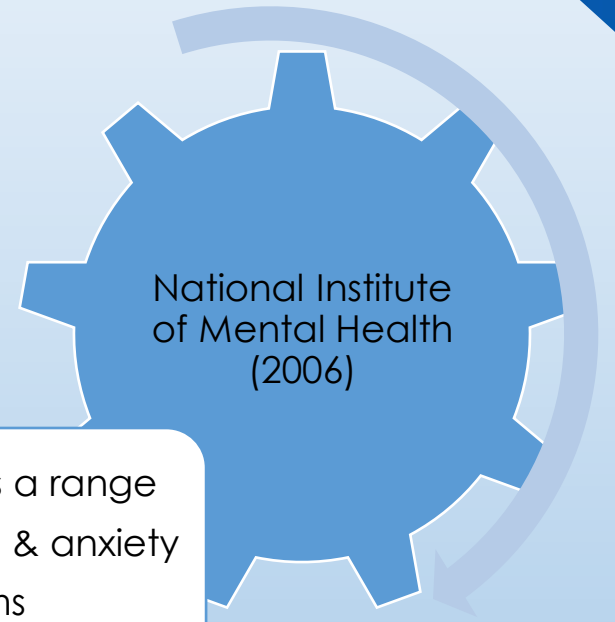
- Fear of abandonment
- Conviction of unlovability
- Exaggerated guilt

Cognitive Behavioural Therapy

(CBT)

Therapy focuses on

- Decreasing "dichotomous thinking"
- Better control over emotions & impulses
- Strengthen the patient's sense of identity



- Reduces a range of mood & anxiety symptoms
- Reduces suicidal or self-harming behaviours

Dialectical Behaviour Therapy (DBT)

Marsha Linehan (1993)

Term 'dialectical'

- Synthesis of opposites
- Polarized opposite feelings
- Attitudes of the patient
- Need for acceptance and for change

- Minimizes suicide or attempts of self-harm behaviours
- Combines standard CBT techniques (emotion regulation) with Mindfulness, Distress tolerance, Acceptance & Interpersonal effectiveness
- One individual session per week with a therapist & Weekly group session
- Phone calls to the therapist are allowed

Condition:

- Conversation lead to the abstention (suicide or self-cut)
- Cut short the call if the patient calls after having self-damaging

Dialectical Behaviour Therapy

(DBT)

Marsha Linehan (1993)

First randomized clinical trial of DBT

(Dimeff & Linehan, 2001)

- Reduced rates of suicidal gestures
- Reduces psychiatric hospitalizations
- Reduces treatment drop-outs

Meta-analysis

(Kliem, Kröger & Kosfelder, 2010)

- Moderate effects in individuals with BPD

Systematic review

(Binks et al., 2006)

- Showed no differences between DBT and treatment as usual

Dialectical Behavioural Therapy

DBT

New York-Presbyterian Hospital

https://www.youtube.com/watch?v=KJA53I91LSk

NYP

NewYork-Presbyterian
The University Hospital of Columbia and Cornell

Psychodynamic Psychotherapy (PDP)

Polarized attitudes and oscillating behaviours

Unconscious forces and conflicts are buffeting the patient

Promotes psychic integration

Client-therapist relationship must be strong

1 to 3 times a week face-to-face with the patient

(American Psychiatric Association, 2001)

Transference-Focused Psychotherapy (TFP)

Psychodynamic treatment

Patient's confused and contradictory sense of identity

Disturbed relationships

Splitting or dichotomous thinking as defense mechanisms

Focus of treatment: Distorted perceptions of self & others

transfe rence

Reassignation of extreme + or – images from one person to another

Mechanism of change: interpretation of distorted perceptions

- Learn to reflect feelings
- Intense changes in emotions

Transference-Focused Psychotherapy (TFP)

Clarkin, Foelsch & Levy (2001)

- Suicide attempts reduced
- Physical condition improved
- Decrease in psychiatric hospitalizations
- The dropout rate: 19.1%

Clarkin, Levy & Schiavi (2005)

- Decreases in psychiatric visits and hospitalizations
- Increases in global functioning

Group therapy

Not harmful and helpful (American Psychiatric Association, 2001)

Combined with individual Dynamic Therapy and group therapy:

The greatest therapeutic power (McGlashan, 1986)

Homogeneous group of BPD is recommended

Dependent, schizoid and narcissistic personality disorders or chronic depression

Antisocial personality disorder, untreated substance abuse, or psychosis

Therapeutic communities

TCs

Structured environments where people with a range of complex psychological conditions and needs come together to interact and take part in therapy

Aim → help people with emotional and self-harming problems by teaching them social interaction skills

Most TCs are residential, such as in large houses, where people can stay for around one to four days a week

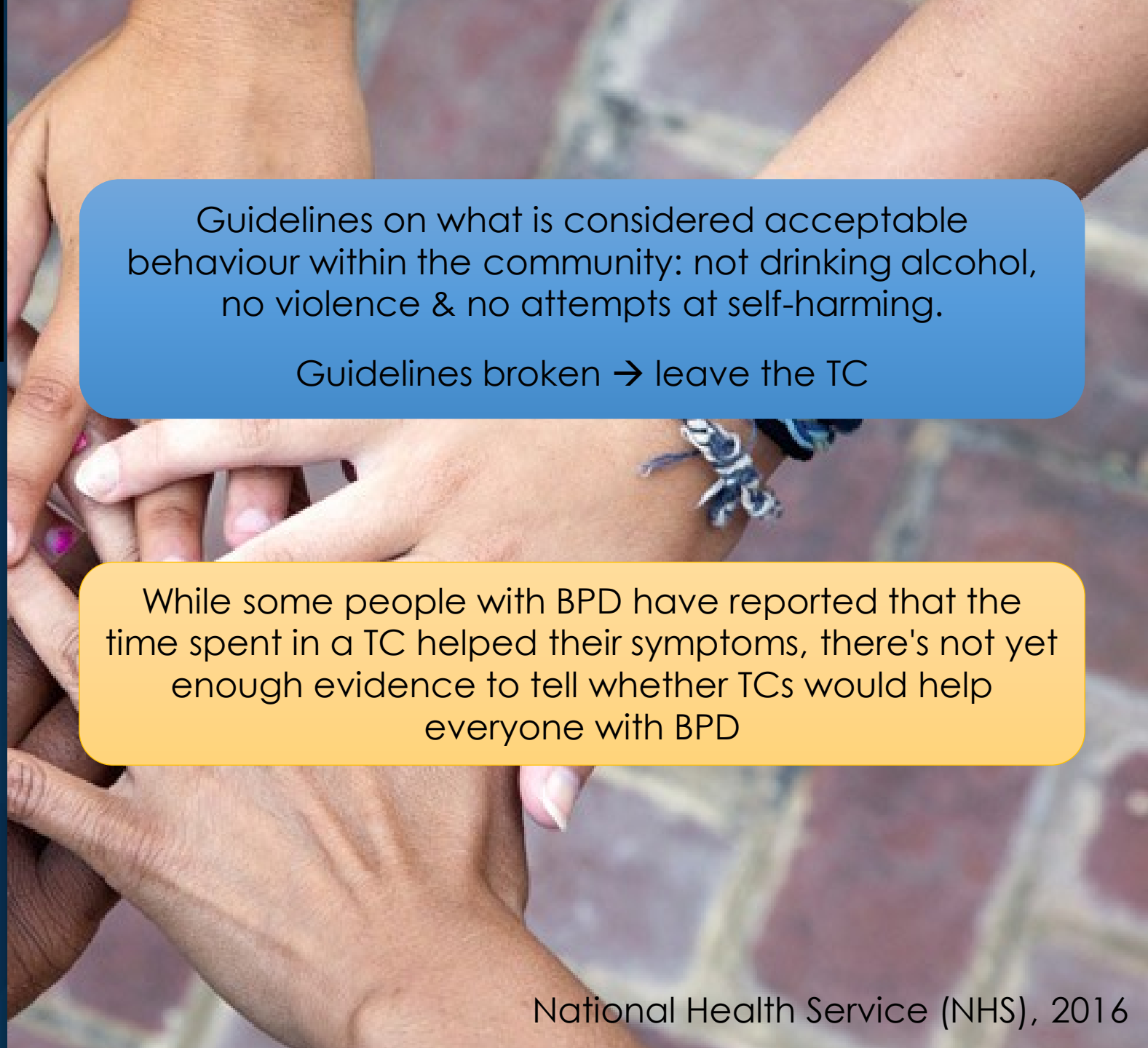
Taking part in individual & group therapy + doing other activities to improve social skills and self-confidence, i.e.:

- ✓ Household chores
- ✓ Meal preparation
- ✓ Games, sports & other recreational activities
- ✓ Regular community meetings – people discuss issues that have arisen in the community

National Health Service (NHS), 2016

Therapeutic communities

TCs



Guidelines on what is considered acceptable behaviour within the community: not drinking alcohol, no violence & no attempts at self-harming.

Guidelines broken → leave the TC

While some people with BPD have reported that the time spent in a TC helped their symptoms, there's not yet enough evidence to tell whether TCs would help everyone with BPD

National Health Service (NHS), 2016

Online spaces

Support groups

Some organizations now offer online support groups, discussion boards, blogs & online communities as additional ways to connect with others in similar situations.

It can be an additional support for in-person groups and may be especially helpful if there are no groups in the area where the patient lives.

- Fellow members of online spaces offer validation
- Members give tips and techniques that have worked for others.

Mental Health America has its own support community through Inspire which enables individuals to connect on a variety of issues and topics related to mental health.

Other types of psychotherapy

- Supportive Psychotherapy
- Dynamic Deconstructive Therapy (DDT)
- Schema-Focused Therapy (SFT)
- Mentalization-Based Therapy (MBT)

Research is needed to improve other core features of this disorder (Skodol et al., 2005)

Combination of psychotherapies

Pharmacotherapy with psychotherapy

Unclear

Fluoxetine (antidepressant)

+

Dialectical Behaviour Therapy

=

No benefits (Simpson and colleagues, 2004)

Olanzapine (antipsychotic)

+

Dialectical Behaviour Therapy

=

An additional benefit (Soler et al. 2005)

No Benefit in other study (Linehan, McDavid, Brown, Sayrs & Gallop, 2008)

Fluoxetine and interpersonal therapy was superior to fluoxetine plus clinical management

Family therapy

Family members may aggravate their relative's symptoms

Some therapies include family members

➡ Help them understand and support BPD individuals

(National Institute of Mental Health, 2016)

Few in number

Most authors seem to recommend psychoeducation

(Sansone & Sansone, 2009).

Family therapy

Systems Training for Emotional Predictability and Problem Solving

Blum et colleagues (2008)

(STEPPS)

- Group treatment
- 20 weeks
- Educate family members
- Supplement other treatments
- includes cognitive behavioral elements
- Skills training
- Encourages the participation of family members

Psychoeducation

- Only one published study of family therapy for patients with BPD ➡ Psychoeducational approach (Gunderson, 2009)
- Improve communication and diminish conflict
- Published clinical reports differ about their family treatment recommendations

Greater knowledge about BPD was associated with greater family member distress, burden, depression, and hostility Hoffman et al. (2003)

~~Family support~~

Common reason to stop the treatment

Couples therapy

APA Practice Guideline (American Psychiatric Association, 2001)

- Only clinical experience
- Useful
- Not recommended as only form of treatment
- Not recommended when partner is unable to listen to the other's criticisms (Seeman, & Edwardes-Evans, 1979).

- Settle and strengthen the relationship
- Clarify the nonviability of the relationship
- Educate and clarify for the partner of the BPD patient the process that is taking place
- May struggle to accommodate the patient's alternating patterns of idealization and depreciation

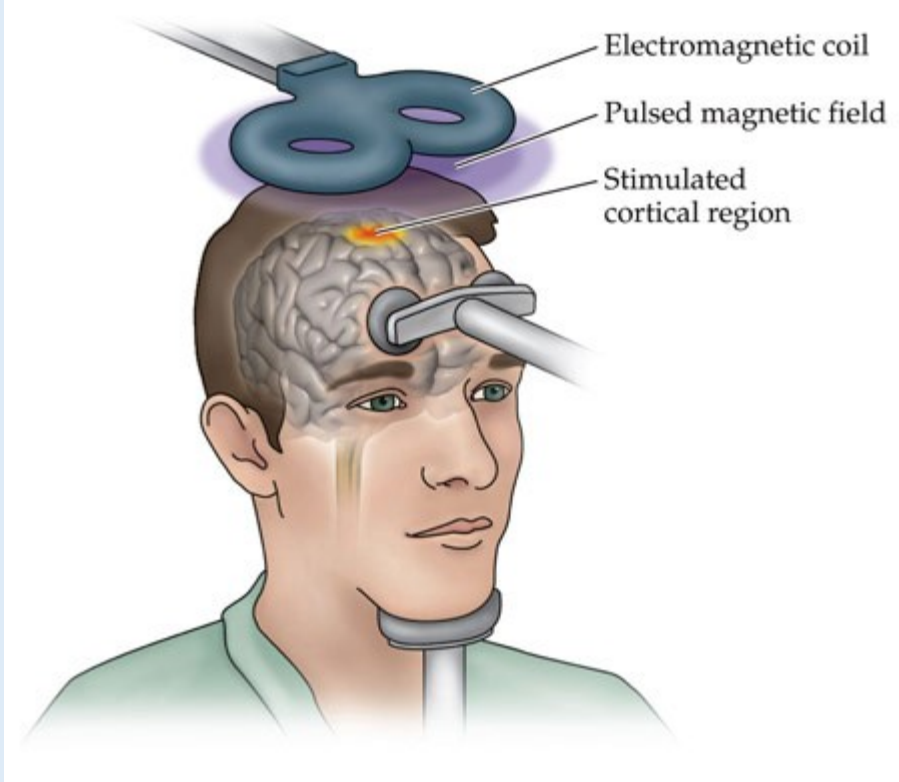
SPOUSE →

- dysphoric and self-doubting,
- too attentive and exhibit reaction formation .

- Explore and change maladaptive reactions and problematic interactions

Transcranial magnetic stimulation (TMS)

Improvements in
- Impulsivity
- Suicidality
- Agression



McKenzie & Nasrallah (2003)