Borderline Personality Disorder (BPD)

PSX_003 Counselling Psychology – PhDr. Pavel Humpolíček, Ph.D

Autumn 2016

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1 Definition

Borderline personality disorder (BPD) is a serious mental disorder marked by a pattern of ongoing instability in moods, behavior, self-image, and functioning. These experiences often result in impulsive actions and unstable relationships. A person with BPD may experience intense episodes of anger, depression, and anxiety that may last from only a few hours to days (National Institute of Mental Health, 2016).

2 Criteria

2.1 DSM-5

According to the DSM-5 (American Psychiatric Association, 2013), **Borderline Personality Disorder (BPD) (301.83)** is a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Frantic efforts to avoid real or imagined abandonment. (Note: Do not include suicidal or self-mutilating behaviour covered in Criterion 5).
2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.
3. Identity disturbance: markedly and persistently unstable self-image or sense of self.
4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). (Note: Do not include suicidal or self-mutilating behaviour covered in Criterion 5).
5. Recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour.
6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).
7. Chronic feelings of emptiness.
8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
9. Transient, stress-related paranoid ideation or severe dissociative symptoms.

DSM-5 also gathers associated features that support diagnosis. This features are briefly described below.

Individuals with BPD may undermine themselves at the moment a goal is about to be achieved (e.g., dropping out of school just before graduation, destroying a good relationship just when it is clear that the relationship could last, etc.). Furthermore, individuals with this disorder may feel more secure with transitional objects (i.e., a pet or inanimate possession) than in interpersonal relationships.

Some individuals develop psychotic-like symptoms during times of stress (e.g., hallucinations, body-image distortions, ideas of reference, hypnagogic phenomena). Besides, premature death from suicide may occur in these individual, especially in those with co-occurring depressive disorders or substance use disorders. Physical handicaps may result from self-inflicted abuse behaviours or failed suicide attempts.

Recurrent job losses, interrupted education, and separation or divorce are also common. Physical and sexual abuse, neglect, hostile conflict, and early parental loss are more common in the childhood histories of those with BPD.

2.2 ICD-10

On the other hand, the ICD-10 (World Health Organization, 1992) defines a disorder conceptually similar to BPD called **Emotionally unstable personality disorder (F60.3)**. It has the following two subtypes:

1. F60.30 Impulsive type

At least three of the following must be present, and one of which must be number "2":

1. Marked tendency to act unexpectedly and without consideration of the consequences.
2. Marked tendency to engage in quarrelsome behaviour and to have conflicts with others, especially when impulsive acts are thwarted or criticized.
3. Outbursts of anger or violence, with inability to control the resulting behavioural explosions.
4. Difficulty in maintaining any course of action that offers no immediate reward.
5. Unstable and capricious (impulsive, whimsical) mood.

2. F60.31 Borderline type

   At least three of the symptoms mentioned in *F60.30 Impulsive type* must be present and, in addition, at least 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, often leading to emotional crisis.
    3. Excessive efforts to avoid abandonment.
    4. Recurrent threats or acts of self-harm.
    5. Chronic feelings of emptiness.
    6. Demonstrates impulsive behaviour (e.g., speeding, substance abuse).

3 Development and Course

The course of BPD is considerably variable. The most frequent pattern is a chronic instability in early adulthood, with events of severe affective and impulsive dyscontrol and high levels of use of health and mental health resources.

The impairment from the disorder and the risk of suicide are greatest in the young-adult years and gradually decreases with advancing age. Although the tendency toward intense emotions, impulsivity, and intensity in relationships is often lifelong, individuals who engage in therapeutic intervention often show improvement beginning sometime during the first year. During their 30s and 40s, the majority of individuals with this disorder attain greater stability in their relationships and vocational functioning.

Follow-up studies of individuals identified through outpatient mental health clinics show that after about 10 years, as many as half of the individuals no longer have a pattern of behaviour that meets full criteria for BPD. This disorder seems to be less stable over time than expected for personality disorders (Skodol et al., 2005; Lenzenweger et al., 2007; Gunderson et al., 2003).

4 Prevalence

According to the DSM-5 (American Psychiatric Association, 2013), the average population prevalence of BPD is around 1.6% but it can be as high as 5.9%, and it is diagnosed predominantly in females (about 75%).

In primary care settings, the prevalence is about 6%; among individuals seen in outpatient mental health clinics it is about 10%; and among psychiatric inpatients, about 20%. Besides, the prevalence of BPD may decrease in older age groups.

5 Etiology

5.1 Genetic and brain factors

There is significant scientific evidence that BPD is highly heritable. BPD is about five times more common among first-degree biological relatives of people with the disorder than in the general population (American Psychiatric Association, 2013).

A systematic review of the heritability of BPD from Amad, Ramoz, Thomas, Jardri & Gorwood (2014) examined 59 published studies and concluded that BDP has a strong genetic component. They also state that brain abnormalities of this disorder are a consequence of genes involved in brain development. BPD must be regarded as a serious disabling brain disorder.

42 published studies found out that, compared with healthy controls, people who have BPD present extensive cortical and subcortical abnormalities in brain structure and function (McKenzie & Nasrallah 2013). Those studies have revealed some abnormalities in BPD such as: hypoplasia of the hippocampus, variations in the CA1 region of the hippocampus and subiculum, a smaller frontal lobe, a higher glutamate level in the anterior cingulate cortex, greater activation of the amygdala and prolonged return to baseline, a decrease in inter-hemispheric connectivity between right and left anterior cingulate cortices.

5.2 Environmental factors

Growing up in an unstable, abusive, or neglectful environment may raise the risk of developing BPD. Of all environmental factors that place a person at risk for developing borderline disorder, those associated with poor or uninformed parenting appear to be the most critical. (Leichsenring, Leibing, Kruse, New, & Leweke, 2011; Judd & McGlashan, 2008; Reich & Zanarini, 2001). Early separation from one or both parents, repeated emotional, physical or sexual abuse by someone within or outside of the family environment and inconsistent or unsupportive care are included. Poor parenting can also include failing to protect the child from repeated abuse by the other parent, another member of the family or an outsider.

Linehan (1993) also postulates that one of the major causative factors of BPD is an "invalidating environment," defined as one in which communication of private experiences is met by erratic, inappropriate, or extreme responses. That environment is usually the family. But of course, it is important to include that children who have not been exposed to environmental traumas can still develop borderline disorder.

5.3 The Gene-environment interaction model

The G×E interaction model support that expression of plasticity genes is modified by childhood experiences and environment, such as physical or sexual abuse. Childhood abuse might, therefore, disrupt certain neuroplasticity genes, culminating in morphological, neurochemical, metabolic, and white-matter aberrations—leading to pathological behavioral patterns identified as BPD (Amad, Ramoz, Thomas, Jardri & Gorwood, 2014)

6 Diagnosis

Unfortunately, BPD is often underdiagnosed or misdiagnosed. In some cases, co-occurring mental illnesses may have symptoms that overlap with BPD, making it difficult to distinguish BPD from other mental illnesses. For example, 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). Diagnosis is often a relief when people with BPD realize that others understand their experience and treatment options exist.

6.1 Differential Diagnosis

According to the DSM-5 (American Psychiatric Association, 2013), BPD commonly coexist with depressive and bipolar disorders, substance use disorders, eating disorders (notably bulimia nervosa), posttraumatic stress disorder and attention-deficit/hyperactivity disorder, among others.

BPD must be distinguished from personality change due to another medical condition, in which the traits that emerge are a consequence of the effects of that medical condition on the central nervous system. Secondly, BPD must also be distinguished from symptoms that may develop in association with persistent substance use. Thirdly, it should also be distinguished from an identity problem, which is reserved for identity concerns related to a developmental phase (e.g., adolescence) and does not qualify as a mental disorder.

7 Impact on functioning

People with BPD can feel angry at members of their family and alienated from them. It is hard for the family members to cope with them, they often feel angry and helpless at how their family members relate to them. In addition, parents of BDP patient can have a bad behavior, for example, over-involved and under-involved in family interactions (Allen & Farmer, 1996) Incest, for example, may be a type of as extreme and inappropriate overinvolvement of, for instance, a father with his daughter.

High levels of chronic stress and conflict, decreased satisfaction of romantic partners, abuse, and unwanted pregnancy may result from a romantic relationships with BDP partner. However, these links may apply to personality disorders in general (Daley, Burge & Hammen, 2000).

Splitting is a major defense mechanism of patients with BPD. This consist on often regarding self and others as "all good" or "all bad", without middle ground. Splitting has a significant impact in borderline person's life and their relationships. This phenomenon is closely related to what Beck & Freeman (1990) called "dichotomous thinking" and what Linehan (1993) referred to as "all or none thinking." Splitting is described in the American Psychiatric Association's Diagnostic & Statistical Manual (DSM-5) as "A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation."

People who are regarded as being "all good" (idealization) are sometimes referred to as being "split white" or "painted white". People who are regarded as being "all bad" are sometimes referred to as being "split black" or "painted black" (devaluation). Since there is no middle ground, these individuals can go from idealization to devaluation in a short period of time. For instance, a mother may habitually tell her daughter that she is "useless" or "worthless" but when she gets a good grade at school praise and say things like "we are all so proud of you!"

Psychotherapy must be orientated to help the patient begin to experience the shades of grey between the extremes and integrate the positive and negative aspects of the self and others. A major challenge of psychotherapy is to help patients recognize that their perception of others, including the therapist, is a *representation* rather than how they really are.

7.1 Psychopathology in the extended families of BPD

There are four common associated areas of familial psychopathology: mood disorders; impulse disorders; substance use disorders; and Axis II disorders including BPD. It seems that the families of patients with BPD partially mirror the psychopathology encountered in the probands.

Various psychopathological characteristics in the extended of BDP probands in comparison with the extended families of a control proband have been examined in a number of studies. Davidson and Siever (1991) made a study where they compared the relatives of: individuals with BPD; individuals with other personality disorders; and individuals with schizophrenia. They found out that the relatives of BPD probands presented higher risks for affective and impulse disorders. Goldman, D'Angelo and De Maso (1993) found that the relatives of BPD individuals had significantly greater rates of depression, substance abuse and antisocial characteristics as well.

Finally, in a large study by Zanarini (2004), they found that the families of BPD probands were more likely to have BPD psychopathology compared with the non BPD probands, particularly subsyndromal symptoms.

7.2 Psychopathology in the parents of BPD patients

As reported by some studies with both parents, the individuals with BPD described their parents in a negative way (Guderson, 1997), uncaring and overcontrolling (Zweig-Frank , Paris J., 1997; Weaver, Clum, 1993; Parker, Roy, Wilhelm, et al, 1999), unempathetic (Guttman, Laporte, 2000), conflictual (Allen, Abramson, Whitson, et al, 2005), invalidating and critical (Fruzzetti, Shenk, Hoffman, 2005), aversive , less nurturing, and less affectionate (Johnson, Cohen, Chen, et al, 2006) ,emotionally withholding (Zanarini, Gunderson, Marino, et al., 1989), over-protective (Torgersen, Alnaes . 1992; Gagnon, 1993), over-involved as well as under involved (Allen , Farmer, 1996) and hostile (Hayashi , Suzuki , Yamamoto, 1995).

Nickell et al. (2002) found that BPD features were associated with insecure attachment (i.e., anxious or ambivalent attachment) and the perception of a lack of caring from the mother. Bandelow et al. (2005) found that the BPD subsample described the attitude of their parents toward them as significantly more unfavorable in all aspects.

Overall, these studies portray the parents of patients with BPD in a very unflattering light. There is a limitation in this kind of studies since the patients can have distorted perceptions of

parents because of their inherent difficulties with emotional regulation. Thus, the result may not be objective.

In addition to studies examining the general impressions of both parents, there are other studies about the specific relationship between the BDP individual and the mother. In those studies (Golomb, Ludolph & Westen, 1994; Paris & Frank, 1989; Bezirganian, Cohen & Brook 1993; Liotti & Pasquini, 2000), those with BPD have described their mothers as egocentric (i.e. using the child for their own ego-gratifying needs), less caring, inconsistent and overinvolved.

There are not too many studies about the specific relationship of the BPD individuals with their fathers. Fathers were rated particularly negatively by BPD patients (Baker et al., 1992). The researchers found that this negative response was related to the age of the BPD individual as well as if fathers were perpetrators of sexual abuse.

7.3 Children of mothers with BPD

The effects of BPD mothers on their children have been examined by several studies, usually with a control group. For instance, Hobson and colleagues (2005) found that mothers with BPD were found to be less available for positive engagement, disorganized and intrusively insensitive. Barnow and colleagues (2006) compared the children of BPD mothers with those of depressed mothers, mothers with personality disorders and mothers without psychopathology. They discovered that the children of BPD mothers had lower self-esteem, exhibited more emotional and behavioral problems and were more harm avoidant.

Furthermore, the study of Weiss et al. (1996) showed that children of BDP mothers compared with children of mothers with a non BPD personality disorder were more impulsive and had more psychiatric diagnoses, including a higher prevalence of BPD. Finally, Newman et al. (2007) saw that BPD mothers were less sensitive in their interactions with offspring, and likewise, the children had less desire to interact, were less satisfied, less competent and more distressed.

8 Treatment and Therapies

BPD has historically been viewed as difficult to treat. However, with newer and proper treatment, many people with BPD experience fewer or less severe symptoms and an improved quality of life. Many circumstances affect the length that it takes for symptoms to improve once

treatment begins, so it is important for people with BPD and their relatives, couple, friends and others to be patient and to receive appropriate support during treatment. (National Institute of Mental Health, 2016).

Psychotherapy is the primary treatment for BPD, while medications are useful for treating comorbid disorders, such as depression and anxiety. Besides, short-term hospitalization has not been found to be more effective than community care for improving outcomes or long-term prevention of suicidal behavior in those with BPD (Paris, J., 2004).

8.1 Medication

A systematic review and meta-analysis of randomised controlled trials (RCT) by the Cochrane collaboration (Stoffers et al., 2010) found that there was no fully effective medication for the core BPD symptoms (chronic feelings of emptiness, identity disturbance and abandonment), but they did found that some medications could impact isolated symptoms of BPD or the symptoms of comorbid conditions. They exposed the following results:

Among the habitual **antipsychotics** used in BPD, they found that *haloperidol* may reduce anger and *flupenthixol* may reduce the likelihood of suicidal behaviour. Of the atypical antipsychotics studied in relation with BPD, one trial found that *aripiprazole* may reduce interpersonal problems and impulsivity. *Olanzapine* may decrease affective instability, anger, psychotic paranoid symptoms, and anxiety, but a placebo had a greater ameliorative impact on suicidal ideation than olanzapine did. They also found that the effect of *ziprasidone* was not significant.

Of the **mood stabilizers** studied, *valproate semisodium* may ameliorate depression, interpersonal problems, and anger. *Lamotrigine* may reduce impulsivity and anger; *topiramate* may ameliorate interpersonal problems, impulsivity, anxiety, anger, and general psychiatric pathology. The effect of *carbamazepine* was not significant.

In relation to the **antidepressants**, they found that *amitriptyline* may reduce depression, but *mianserin*, *fluoxetine*, *fluvoxamine*, and *phenelzine sulfate* showed no effect. Finally, *omega-3 fatty acid* may ameliorate 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.

As can be seen, medication effectiveness evidence is weak. Thus, and because of the potential for serious side effects from some of these medications, the 2009 UK National Institute for Health

and Clinical Excellence (NICE) clinical guideline for the treatment and management of BPD recommends that medication should not be used specifically for BPD and its individual symptoms or associated behaviour. However, it can be considered in the general treatment of comorbid conditions. They propose a review of the treatments of those with BPD and a current medication prescription who do not have a diagnosed comorbid mental or physical disorder. In this way, some evidence could be found to avoid what they see as an unnecessary drug treatment (Abraham, Kelly, West & Michie, 2009).

8.2 Psychotherapy

Psychotherapy is the main treatment for people with BPD (Leichsenring et al., 2011). According to current research, psychotherapy may alleviate some symptoms, but additional studies are needed to better understand how psychotherapy works (National Institute of Mental Health, 2016).

Psychotherapy can be provided one-on-one or in a group setting. Group sessions may teach people with BPD how to interact with others and how to effectively express themselves. It is important that people in therapy get along with and trust their therapist, although this might be difficult because of the nature of BPD itself. There are several types of psychotherapy used to treat BPD. Some of them will be mentioned below.

8.2.1 Cognitive Behavioural Therapy (CBT)

The aim of CBT is to help people with BPD identify and change those core beliefs and/or behaviors that cause inaccurate perceptions of themselves and others as well as problems interacting with others. Thus, CBT place emphasis on observable behaviours and on the psychic schemata or "inner scripts" (usual patterns of thought that concern the self and interpersonal world, built up during developmental years). In the evolution of BPD, those behaviours and their underlying schemata may have become maladaptive for diverse causes: hereditary predispositions, humiliations or other psychological hurts by parents, or even trauma originated from physical or sexual abuse (Beck and Freeman, 1990).

That early maladaptive schemata include basic assumptions as: "I'll be alone forever"; "no one will be there for me"; "I'm a bad person"; "I deserve to be punished"; "No one would love me if they really got to know me". These assumptions reflect some important

themes relevant to BPD patients such as fear of abandonment, conviction of unlovability and exaggerated guilt. The cognitive distortions typical of BPD patients involve polarized all-or-none attitudes, which Beck & Freeman (1990) refer to as "dichotomous thinking".

Therapy focuses on decreasing that tendency to dichotomous thinking, helping the patient develop better control over his emotions and impulses, and strengthening the patient's sense of identity (Stone, 2006). According to the National Institute of Mental Health (2006), CBT may help reduce a range of mood and anxiety symptoms and reduce the number of suicidal or self-harming behaviours.

In the last 20 years, the **Dialectical Behaviour Therapy (DBT)** developed by Marsha Linehan (1993) has increased its popularity and respectability as a method specially for minimizing the tendency among BPD patients to make suicide attempts of self-harm behaviours. It combines standard CBT techniques for emotion regulation with concepts of mindfulness, distress tolerance, acceptance, and interpersonal effectiveness. It includes the use of one individual session per week with a therapist, along with a weekly group session oriented toward skills training. Phone calls to the therapist are allowed (whereas they are discouraged in Transference-Focused Psychotherapy –which we will be mentioning below–), but with the condition that the therapist will speak with the patient who is about to self-cut or make a suicide gesture, with the expectation that their conversation will lead to the abstention in the patient from self-damaging and the ability to acquire self-control. If the patient calls after having self-damaging, the call must cut short to avoid the possible "secondary gain" that the patient might obtain from being listened by other, in this case the the therapist.

The term "dialectical" means a synthesis or integration of opposites, those polarized opposite feelings and attitudes of the patient. It includes the need for acceptance and the need for change. Thus, DBT therapists accept clients as they are while also acknowledging that they need to change in order to reach their goals. For instance, many BPD patients have been abused in childhood, hence the *validation* during the therapy becomes crucial to reassure the patient that certain negative experiences such as neglect, unjustified punishment or incest really happened and that the patient was not "crazy" for having thought, e.g. "I am a bad person". What is more, all of the skills and strategies taught in DBT are balanced in terms of acceptance and change (mindfulness and distress tolerance

in acceptance-oriented skills and emotion regulation and interpersonal effectiveness in change-oriented skills).

The first randomized clinical trial of DBT showed reduced rates of suicidal gestures, psychiatric hospitalizations, and treatment drop-outs when compared to treatment as usual (Dimeff & Linehan, 2001). Besides, a meta-analysis found that DBT reached moderate effects in individuals with borderline personality disorder (Kliem, Kröger & Kosfelder, 2010). Nonetheless, a 2006 systematic review from the Cochrane collaboration showed no differences between DBT and treatment as usual in individuals meeting criteria for BPD at 6 months, or in hospital admissions in the previous 3 months (Binks et al., 2006)

8.2.2 Psychodynamic Psychotherapy (PDP)

The psychoanalytically-oriented or "psychodynamic" methods are rooted on the assumption that unconscious forces and conflicts are buffeting the borderline patient and that is the cause of the polarized attitudes and oscillating behavioural patterns seen in BPD individuals. For example, they usually swing from adoration to contempt toward key figures in their lives (manifesting the defense mechanisms of idealization and devaluation). The psychodynamic approach tries to promote psychic integration through the careful examination of the polarized attitudes in hopes this will lead to more appropriate attitudes toward other people and to more modulated behaviours in everyday life. In this therapy, the client-therapist relationship must be strong; therapists want their clients to be as open and honest as possible with them. For this to happen, clients must trust their therapist.

As reported by the APA Practice Guideline (American Psychiatric Association, 2001), most psychotherapists and psychoanalysts agree that psychoanalytic psychotherapy, at a frequency of one to three times a week face-to-face with the patient, is a more suitable treatment than psychoanalysis.

Transference-Focused Psychotherapy (TFP) is a psychodynamic treatment rooted in the patient's confused and contradictory sense of identity associated with emotionally intense mental images of themselves and others. The defense against these contradictions leads to disturbed relationships with others and with self. For instance, splitting or dichotomous thinking are defense mechanisms. The distorted perceptions of self and others are the focus of treatment as they emerge in the relationship with the therapist (transference).

The therapist helps the patient unconsciously reassign extreme positive or negative images associated with one person to another person, such as the therapist. In that moment, the therapist talks with the patient to interpret and understand why the patient distorts his or her sense of self and images of other people. The consistent interpretation of these distorted perceptions is considered the mechanism of change. Intense changes in emotions occur as patients learn to reflect and verbalize what they are feeling, rather than acting out these emotions impulsively.

In early research from Clarkin, Foelsch & Levy (2001) studying the efficacy of a year-long TFP, suicide attempts were significantly reduced during treatment. Moreover, the physical condition of the patients was significantly improved. When the treatment year was compared to the prior year, they found that there was a significant decrease in psychiatric hospitalizations and days spent as inpatients in psychiatric hospitals. Finally, the dropout rate for the 1-year study was 19.1%, which was a comparable rate to previous studies assessing the treatment of borderline individuals, including DBT research. In another study from Clarkin, Levy & Schiavi (2005) comparing TFP with treatment as usual, TFP group experienced significant decreases in psychiatric visits and hospitalizations during treatment year, as well as significant increases in global functioning when compared to treatment as usual.

8.2.3 Group therapy

In consonance with the APA Practice Guideline (American Psychiatric Association, 2001), the sparse literature on group therapy for BPD patients points that group treatment is not harmful and may be helpful, but it does not provide evidence of any clear advantage over individual psychotherapy. In general, group therapy is usually used in combination with individual therapy and other types of treatment, evidencing the clinical wisdom that the combination is more effective than solely group therapy. Studies of combined individual Dynamic Therapy plus group therapy suggest that unknown components of combined interventions may have the greatest therapeutic power (McGlashan, 1986).

Clinical experience suggests that a reasonably homogeneous group of BPD patients is generally recommended for group therapy, although patients with dependent, schizoid, and narcissistic personality disorders or chronic depression also mix well with BPD individuals

(Gunderson, J. G., 2009). Conversely, it is generally recommended not to include patients with antisocial personality disorder, untreated substance abuse, or psychosis.

8.2.4 Therapeutic communities

Therapeutic communities are structured environments where people with a range of complex psychological conditions and needs come together to interact and take part in the therapy in order to help them with their emotional and self-harming problems teaching them social interaction skills. Most TCs are residential, such as in large houses, where people stay for around one to four days a week (National Health Service, 2016).

As well as taking part in individual and group therapy, you would be expected to do other activities designed to improve social skills and self-confidence, such as household chores, meal preparation, games, sports and other recreational activities and regular community meetings where people discuss issues that have arisen in the community.

This TCs usually set guidelines on what is considered an acceptable behaviour within the community, such as not drinking alcohol, no violence to other residents or staff, and no attempts at self-harming. Those who break these guidelines are usually told to 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.

8.2.5 Online spaces – support groups

Nowadays, some organizations offer online support groups, discussion boards, blogs and online communities as additional ways to connect with others in similar situations. This 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. Thus, in these groups, fellow members offer validation and give tips and techniques that have worked for others.

Mental Health America is an example of community that has its own online support community through the webpage 'www.inspire.com', enabling individuals to connect on a variety of issues and topics related to mental health.

Other types of psychotherapy may be helpful for some people with BPD, such as **Supportive Psychotherapy**, **Dynamic Deconstructive Therapy (DDT)**, **Schema-Focused Therapy (SFT)**

or **Mentalization-Based Therapy (MBT)**. Therapists often adapt psychotherapy to better meet a person's needs, and may also switch from one type of psychotherapy to another, mix techniques from different therapies, or use a combination of psychotherapies.

As we have seen, psychotherapy is beneficial for some clinically relevant problems of patients with BPD. However, further research is needed to also improve other core features of this disorder (Skodol et al., 2005).

8.3 Pharmacotherapy with psychotherapy

The advantages of combining pharmacotherapy and psychotherapy in BPD are still unclear. *Fluoxetine* (**antidepressant**) combined with Dialectical Behaviour Therapy (DBT) did not produce any additional benefit compared with DBT plus placebo (Simpson and colleagues, 2004). However, in a double-blind study of Soler et al. (2005), *olanzapine* (**antipsychotic**) added to DBT provided an additional benefit compared with DBT plus placebo, although no differences were reported in another study made on BPD women with high irritability in favour of the DBT plus olanzapine combined treatment (Linehan, McDavid, Brown, Sayrs & Gallop, 2008). Otherwise, the combination of *fluoxetine* and interpersonal therapy was superior to *fluoxetine* plus clinical management.

Results are very diverse, hence future studies on the combination of pharmacotherapy and psychotherapy are needed to improve the empirical support for its use in BPD patients (Leichsenring et al., 2011).

8.4 Families and couples

Families of people with BPD may also benefit from therapy. The challenges of dealing with a loved one with BPD on a daily basis can be very stressful, and family members may unconsciously act in ways to aggravate their relative's symptoms. Some therapies include family members in treatment sessions to help them understand and support BPD individuals (National Institute of Mental Health, 2016). Although more research is needed to determine the effectiveness of family therapy in BPD, studies on other mental disorders suggest that including family members can help in a person's treatment. There are different levels of possible psychopathology in multiple members, it is the reason why the family intervention must be undertaken with care. Programs for

family members are few in number and most authors seem to recommend psychoeducation (Sansone & Sansone, 2009).

Blum and colleagues (2008) developed an intervention called **Systems Training for Emotional Predictability and Problem Solving (STEPPS)**. It is a group treatment program during 20 weeks. The aim is to educate family members, significant others, and health care professionals about BPD. It gives them guidance on how to interact consistently with the person with the disorder. STEPPS is designed to supplement other treatments the patient may be receiving, such as medication or individual psychotherapy. This program includes cognitive behavioral elements and skills training and also encourages the participation of family members and other significant persons.

On the other hand we have **psychoeducation**, which refers to the education that is offered to individuals with a mental health condition and their families to help to empower them and deal with their condition in an optimal way.

As reported by the APA Practice Guideline (2001), there is only one published study of **family therapy** for patients with BPD (Gunderson, 2009) which found that a psychoeducational approach could greatly improve communication and diminish conflict in the family. Published clinical reports differ about their family treatment recommendations. Some clinicians recommend removing the patient's treatment from the family setting and not attempting family therapy (Gunderson, 2009), while others recommend working with the patient and involve the family too (Shapiro, 1992).

Clinical experience suggests that family work is most apt to be effectiveness and can be of critical importance when patients with BPD have significant involvement with the family. Failure to enlist family support is a common reason to stop the treatment. However, there may be some unexpected risks with psychoeducation, even if it is the predominant theme in the treatment approach to families with a BDP member. Specifically, Hoffman et al. (2003) explored family members' knowledge about BPD. In this study, greater knowledge about BPD was associated with greater family member distress, burden, depression, and hostility toward the patient.

Finally, in accordance with APA Practice Guideline (American Psychiatric Association, 2001), only clinical experience and case reports can give us some information about **couples therapy**. This clinical literature suggests that couples therapy may be an useful and, sometimes, essential adjunctive treatment modality. However, couples therapy is not recommended as the only

form of treatment for patients with borderline personality disorder. Clinical experience suggests that it is relatively contraindicated when either partner is unable to listen to the other's criticisms or complaints without becoming too enraged, terrified, or despairing (Seeman, & Edwardes-Evans, 1979).

According to the the APA Practice Guideline (American Psychiatric Association, 2001), the usual goal of couples therapy is to settle and strengthen the relationship between the partners or to clarify the nonviability of the relationship. Other goal for some is to educate and clarify for the partner of the BPD patient the process that is taking place within the relationship. Partners of BPD patients may struggle to accommodate the patient's alternating patterns of idealization and depreciation as well as other interpersonal behaviours. Thus, spouses may become dysphoric and self-doubting, as well as too attentive and exhibit reaction formation (a defense mechanism from the psychoanalytic theory in which emotions and impulses which are anxiety-producing or perceived to be unacceptable are mastered by exaggeration). The goal of treatment is to explore and change these maladaptive reactions and problematic interactions between partners.

8.5 Transcranial magnetic stimulation

Using neurostimulation techniques such as repetitive transcranial magnetic stimulation and deep brain stimulation to modulate the activity of a given region of the brain seems to have effectiveness in the improvement of impulsivity, suicidality and aggression, as McKenzie & Nasrallah (2003) found correlations between those symptoms and structural brain abnormalities.

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