

Borderline Personality Disorder

BPD

What is Borderline Personality Disorder?



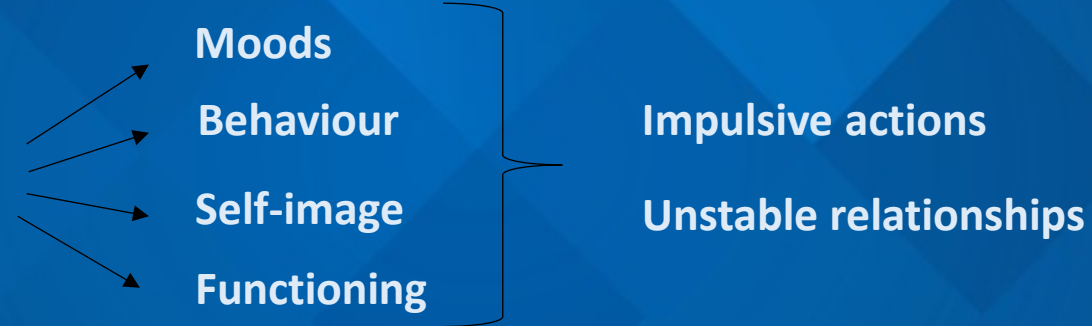
— By Illustrator Shawn Coss —

Definition

Serious mental disorder



Instability in



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)

Associated features

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

Give up goals

**More secure
with transitional
objects**

**Psychotic
Symptoms**

**Job losses,
interrupted
education,
separation/divorce**

Different states of wound healing

Self-damaging



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

Self-damaging



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)

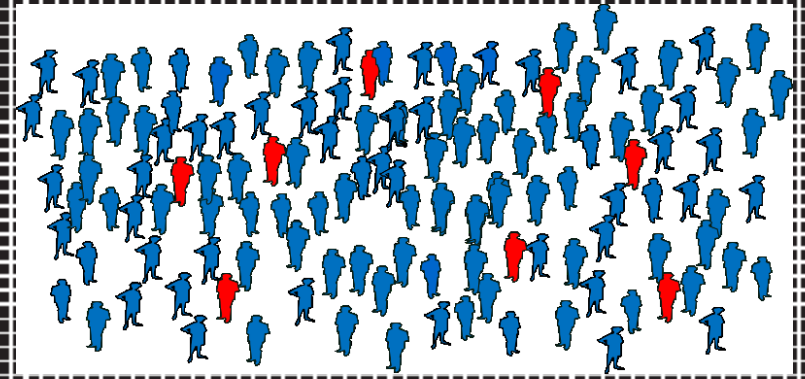
Lifelong tendency toward intense emotions, impulsivity, and intensity in relationships but

Improvement in the first year of therapeutic intervention

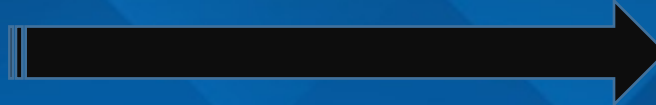


Prevalence

DSM-5 (American Psychiatric Association, 2013)



Average population



Between 1.6%
and 5.9%

Predominantly in females



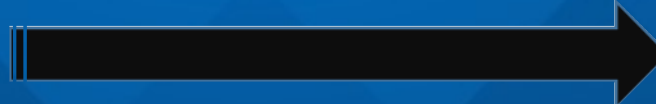
about 75%

Primary care settings



about 6%

Outpatient mental health clinics



about 10%

Psychiatric inpatients



about 20%

Etiology



GENETIC AND
BRAIN FACTORS



GxE

ENVIRONMENTAL
FACTORS



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



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 = split white
- Devaluation = split 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
<ul style="list-style-type: none"> Uncaring and overcontrolling Zweig-Frank , Paris J., 1997; Weaver, Clum, 1993; Parker, Roy, Wilhelm et al. (1999) 	<ul style="list-style-type: none"> Insecure attachment The perception of a lack of caring Nickell et al. (2002) 	<ul style="list-style-type: none"> Not too many studies about fathers Negative image Baker et al. (1992)
<ul style="list-style-type: none"> Unempathetic Guttman, Laporte, 2000 	<ul style="list-style-type: none"> Egocentric Golomb, Ludolph & Westen (1994) 	
<ul style="list-style-type: none"> Conflictual Allen, Abramson, Whitson et al., 2005 	<ul style="list-style-type: none"> Overinvolved Liotti & Pasquini, 2000 	<ul style="list-style-type: none"> Age Perpetrators of sexual abuse
<ul style="list-style-type: none"> Less affectionate Johnson, Cohen, Chen, et al., 2006 		
<ul style="list-style-type: none"> Over-involved / under involved Allen & Farmer, 1996 		
<ul style="list-style-type: none"> More unfavorable in all aspects Bandelow et al. (2005) 		<div style="background-color: #fff9c4; padding: 10px; border: 1px solid black;"> <p>Unflattering light</p> </div>

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

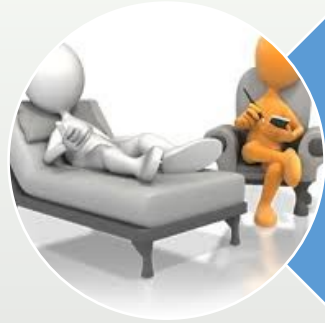
Newman et al. (2007)

Treatment and Therapies



Treatment

It is important to support people with D and their relatives, couple, friends and family to be able to receive appropriate support during treatment (National Mental 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.

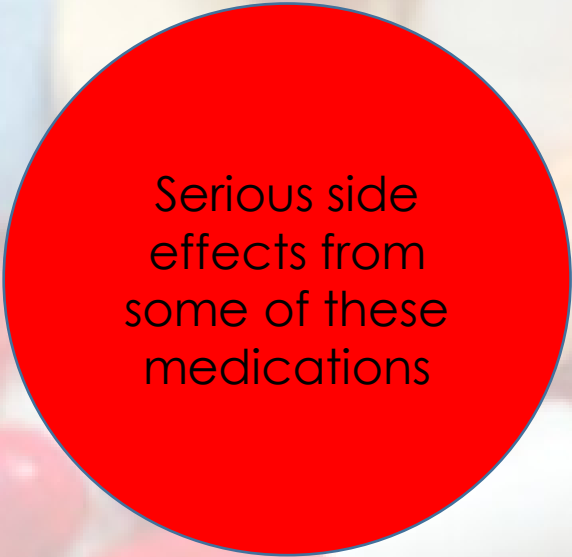
Amitriptyline → depression

Mianserin, fluoxetine, fluvoxamine, and phenelzine sulfate → no effect.

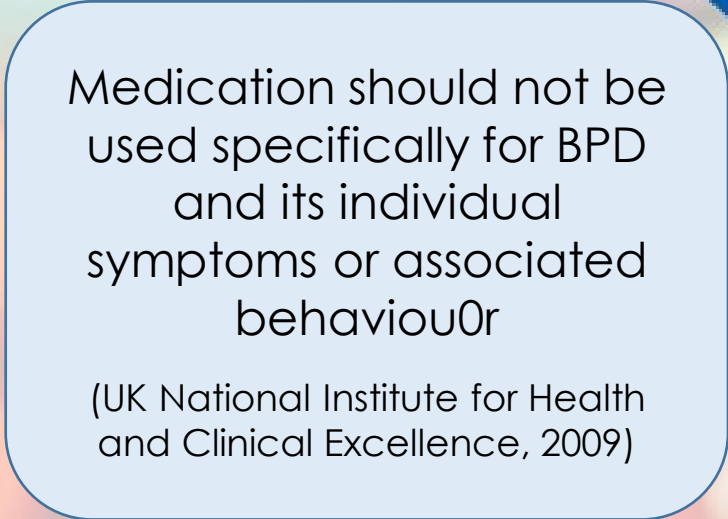
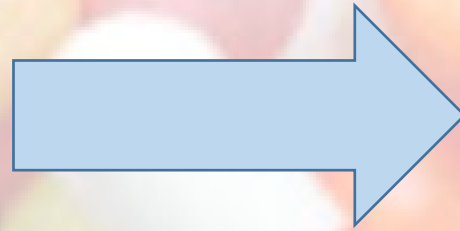
Omega-3 fatty acid → less suicidality and improve depression

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

Medication

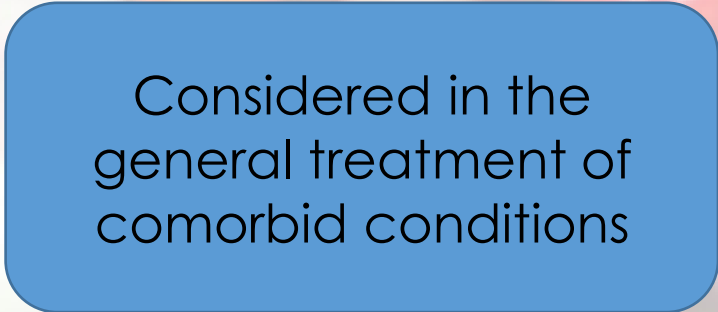


Serious side effects from some of these medications



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

(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

Psychotherapy



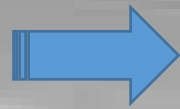
Main treatment for people with BPD
(Leichsenring et al., 2011)



Psychotherapy may alleviate some
symptoms but more studies are needed
(National Institute of Mental Health, 2016)



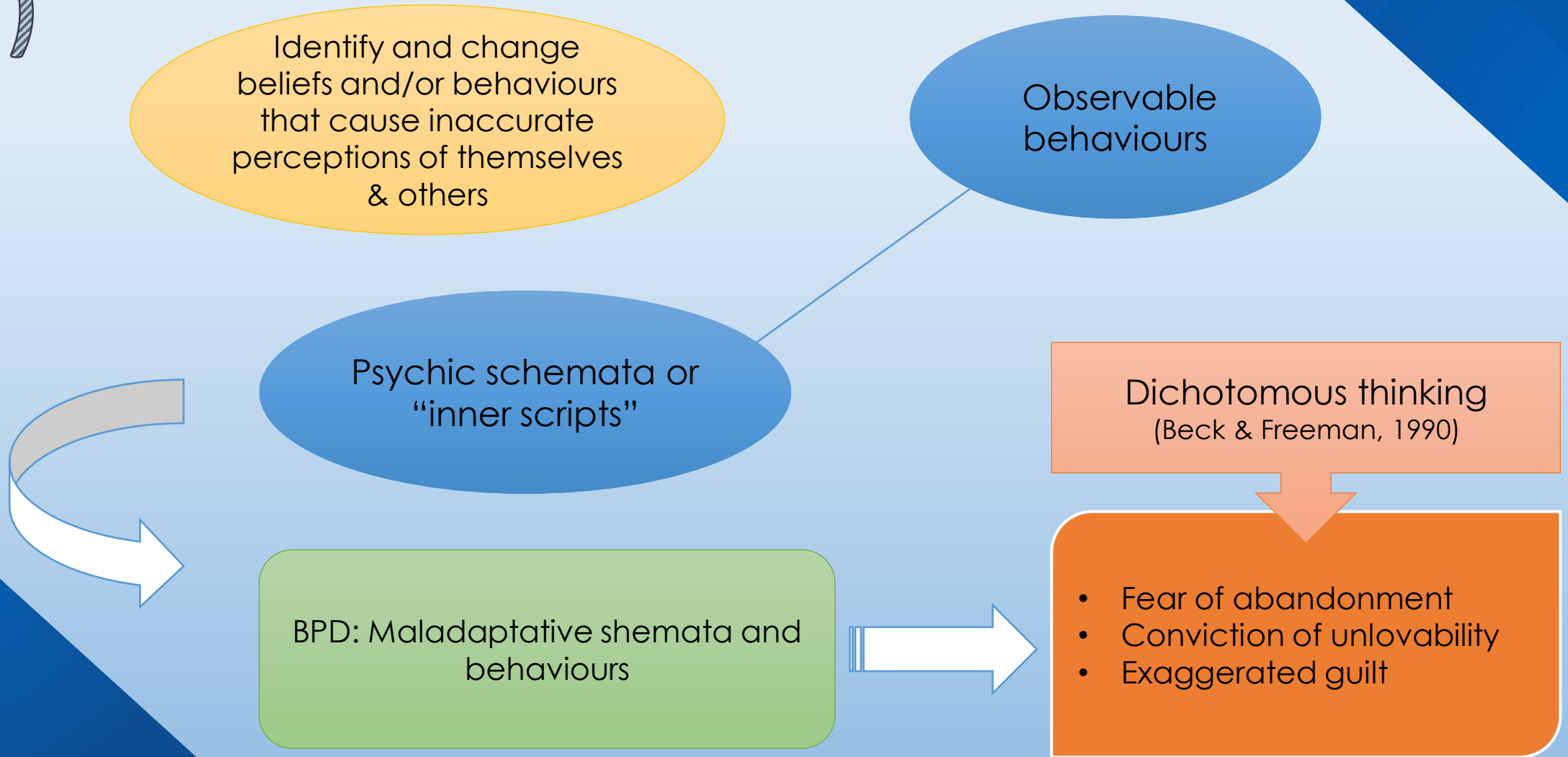
Individual or group format



Trust the therapist

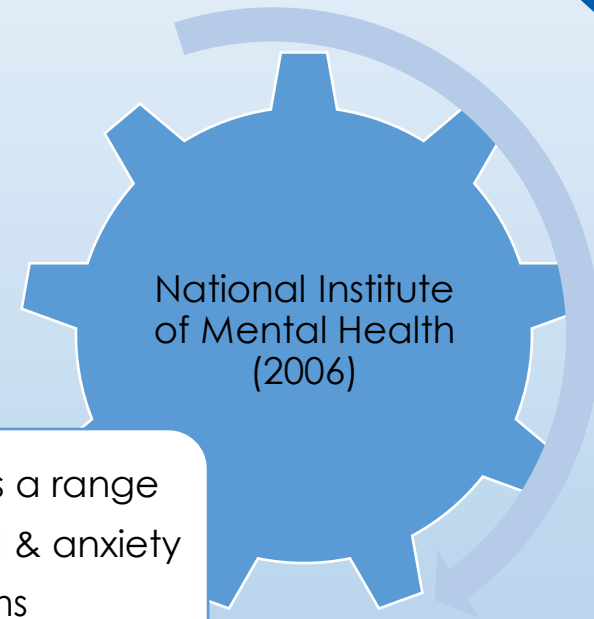
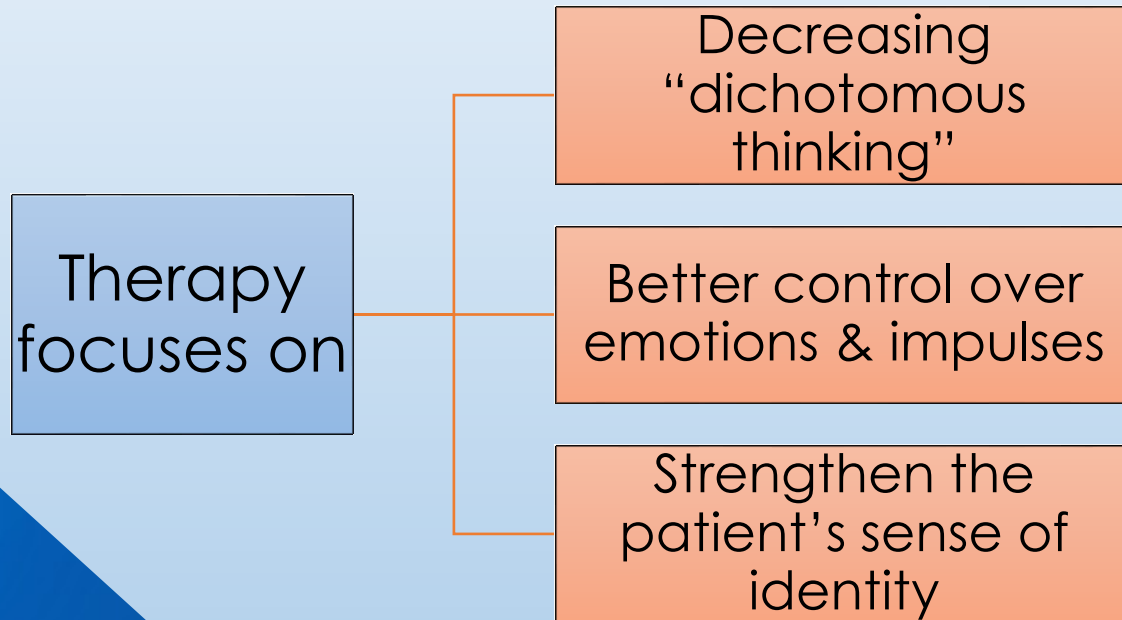
Cognitive Behavioural Therapy

(CBT)



Cognitive Behavioural Therapy

(CBT)



- 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>



 **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

Reassignment 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

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

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)



Fluoxetine and interpersonal therapy was superior to fluoxetine plus clinical management

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

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

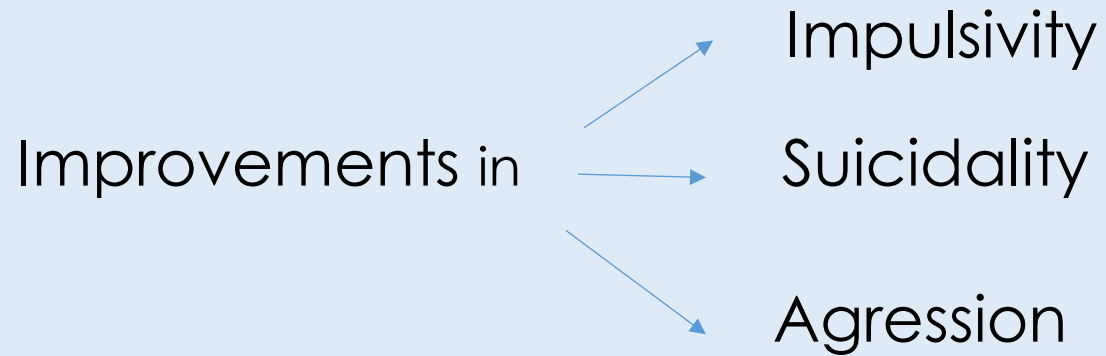
SPOUSE

- dysphoric and self-doubting,

- too attentive and exhibit reaction formation .

- ❖ Explore and change maladaptive reactions and problematic interactions

Transcranial magnetic stimulation (TMS)



McKenzie & Nasrallah (2003)

