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BORDERLINE PERSONALITY DISORDER: TREATMENT

http://www.youtube.com/watch?v=RGVZII_37M4
Diagnostic Criteria

- 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:
  - Frantic efforts to avoid real or imagined abandonment (does not include suicidal behaviors)
  - Pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation
  - Identity disturbance; markedly and persistently unstable self-image or sense of self
  - Impulsivity in two areas that are potentially self-damaging (gambling, unsafe sex, reckless driving)
  - Recurrent suicidal behavior, gestures, threats, or self-mutilation
  - Affective instability due to a marked reactivity of mood
  - Chronic feelings of emptiness
  - Inappropriate, intense anger or difficulty controlling anger
  - Transient, stress-related paranoid ideation or severe dissociative symptoms
Assessment

- **Diagnostic interview**
  - Comprehensive assessment of presentation
  - Familial history
  - Previous medical history, if possible psychiatric history and treatment

- **Personality assessments**
  - MMPI (faking bad or faking good)
  - Personality Assessment Inventory (PAI)
    - Borderline scales have high internal consistency with diagnosis (Nelson-Gray et al., 2010)
Treatment Considerations

The belief that personality disorders are untreatable persists in mental health services today (Swift, 2009)

- Dialectical Behavior Therapy
- Psychodynamic and Psychoanalytic Therapies
- Cognitive Behavioral Therapies
- Pharmacotherapy
Dialectical Behavior Therapy (DBT) By Marsha Linehan

- Only probably-efficacious treatments for BPD per APA Division 12 Task Force
- Based on theoretical orientation of behavioral science, dialectical philosophy, and Zen practice
- There are five basic functions of DBT:
  - improve and expand behavioral capabilities
  - motivate the client to change through diminishing positive reinforcement of negative behavioral patterns
  - generalize therapeutic skills to natural environment
  - improve and expand the therapist’s abilities to increase treatment efficacy
  - assist with changing the client’s environment to reinforce positive behaviors rather than the dysfunctional behaviors
DBT

- 4 Stages
  - Attaining Basic Capacities
  - Posttraumatic Stress Reduction
  - Resolving Problems in Living and Increasing Respect for Self
  - Attaining the Capacity for Freedom and Sustained Contentment

- 4 Treatment Modes
  - Individual Therapy
  - Skills Training
  - Telephone Consultation
  - Consultation Team
Psychodynamic/Psychoanalytic

- Psychoanalytic-Interactional Method (PiM)
  - Widely used in Europe, specifically Germany
  - Found to decreases symptom severity to a degree
  - Premise based on conscious and subconscious experiences regarding interactions that are processed in the here and now
    - Interpersonal processes are examined and understood
    - Validation occurs
Psychodynamic/Psychoanalytic

- **Expressive Psychotherapy/Transference-Focused Therapy (TFT) (Otto Kernberg)**
  - Based on Kernberg’s Object Relations background
  - Focus is on exposure and resolution of intrapsychic conflict
    - Initial goal is to contain suicidal/destructive behavior and therapy-destroying behavior, and identification of early object-relations patterns (through transference)

- **Mentalization Therapy (Bateman and Fonagy)**
  - Intensive therapy based in attachment theory
  - Focus of therapy is to bring “mentalization” to consciousness and facilitate a more controlled sense of mental agency
  - Goal is to increase awareness and recognition of their own mental experiences, thoughts, and feelings
Cognitive Behavioral Therapy

- Schema Focused Therapy (SFT) (Jeff Young)
  - Premise that maladaptive and dysfunctional schema formed during early childhood that manifested in maladaptive and dysfunctional behavioral patterns in adulthood
  - Aim is to identify, challenge, and change schema along with behavioral pattern
  - May employ other forms of behavioral interventions (learning plans, token economy, contingency contracts, etc)
Pharmacotherapy

- Evidence shown that best treatment is combined medication and long-term therapy due to high comorbidity of BPD with an Axis I diagnosis, especially Mood Disorders
- Antipsychotic medications assist with controlling anger, hostility, and psychotic features
- MAO-I’s may help decrease impulsive behaviors
- Anxiolytic medications (especially barbituates) can reduce anxiety and depression
- CAUTION: BPD individuals have a high risk of suicidal behaviors and may have an accidental or purposeful overdose
  - Best practice is to consult as a treatment team to closely monitor medications prescribed
DSM-V Considerations

- Maintains criteria but in narrative form
- Includes Trait/Domains
  - Negative Emotionality
    - Emotional lability
    - Self-Harm
    - Separation Insecurity
    - Anxiousness
    - Low Self-Esteem
    - Depressivity
  - Antagonism
    - Hostility
    - Aggression
  - Disinhibition
    - Impulsivity
  - Schizotypy
    - Dissociation Proneness
Current Research

- Preventative Admission
  - Dutch Community Health Center utilized open psychiatric unit for patients who engaged in suicidal behaviors or ideations (aka “green card for admission”)
  - Provides safe area for patients to go if feeling vulnerable and need resources
  - Expectation is placed on them to adhere to treatments if present and to follow up with outpatient care as directed
  - Pro: Better utilization of healthcare resources, decreased need to draw on crisis/emergent resources, decreased suicide attempts/completions
  - Con: Health insurance coverage prefers short inpatient stays and time-limited outpatient treatment

Psycho-Education

- **Recommended Readings**

- **Websites:**
Case Example

- Ms. Q is a 29 year old, Caucasian woman who is currently admitted into a state psychiatric hospital with Bipolar I Disorder, Most Recent Episode Manic. Upon her admission she had attempted suicide by significantly cutting her wrists immediately after a confrontation between her and the paramour when he did not thank her after she cleaned the entire house from top to bottom without sleep for four days. Her explanation was that she did not mean to cut her wrists so bad but she was in a “bad mood” and cutting her wrists makes her “feel better”. From previous admissions, she has documented at least one major depressive episode and numerous suicide attempts. Ms. Q had her first inpatient psychiatric admission when she was eleven years old and has since been admitted to numerous state and private psychiatric hospitals. She began experimenting with drugs and alcohol at the age of 10. Her family reports that she never maintained a stable relationship and had multiple sexual partners as she grew up. Ms. Q claimed that she loved each one of her previous partners and will still make contact with them when she feels that the relationship could rekindle. She has had thirty consecutive inpatient psychiatric admissions over the past five years. Ms. Q displayed a highly fluctuating affect and mood where she would be observed laughing and joking with peers and report consistent feelings of emptiness to staff. She would often claim she was best friends with her peers and then tell other staff that she hates them because they do not like her or because she is better than them. In therapy sessions she would express feelings of emptiness, fear, and abandonment. She would indicate that she does not want to be alone and asks staff and other patients if they want to stay in her room or at least outside her door.
It was not unusual for Ms. Q to write to other patients that she befriended, indicating she wanted more than friendship. If not reciprocated she would either become highly depressed and reclusive or throw tantrums in the hallways. Ms. Q would repeatedly boast about her accomplishments such as her education where she had obtained a bachelor degree in fine arts and that she wants to continue her education and become an art professor in Rome, Italy. Records indicate that through her admissions she has had numerous aspirations changes from becoming a chef to a business entrepreneur to “just living on the streets”. She also questions her sexual identity, especially when her paramour, who is a male, would visit. She would write love poems and songs for her significant other but once he would be ushered out of the hospital when visitation hours ended she would begin acting out with verbal outbursts of profane and derogatory language of sexual acts she wants to engage in with another female. At other times, when visitation hours came close she would ask her paramour to attempt to become a patient at the same hospital so that they could be together; when he would leave she would tell staff that he reported suicidal ideations with a plan and clear intent. She would often find objects to harm herself such as paper-clips or pens, or would scratch herself repeatedly until she would draw blood. Ms. Q would describe suicidal ideations and increase self-injurious behaviors when discharge was discussed.
Test Questions

- What is the only treatment deemed “probably efficacious” by the APA Division 12 Task Force for BPD?
  - DBT
- What is another treatment used for BPD?
  - TFT, Mentalization tx, SFT, PiM
- What are the pro’s and con’s of preventative measures in treating BPD?
  - Pro: Better utilization of healthcare resources, decreased need to draw on crisis/emergent resources, decreased suicide attempts/completions
  - Con: Health insurance coverage prefers short inpatient stays and time-limited outpatient treatment


