Introduction to Borderline Personality Disorder

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Pre-Test

1- Three words to define BPD?
2- Prevalence BPD? Schizophrenia? Bipolar?
3- Difference in BPD prevalence between men and women?
4- % remission after 10 years?
5- % successful suicide?
6- Neuroimaging specific for BPD?
7- Etiology?
8- Any medication to treat BPD?
9- Other treatments?
10- Three important qualities to be able to work with BPD?
Pre-Test

1- 3 words to define BPD (phenomenology)?
2- Prevalence BPD ? Schizophrenia? Bipolar?
3- Prevalence BPD in men versus women ?
4- Outcome 10 years after Dx ?
5- % successful suicide ?
6- Neuroimaging specific for BPD ?
7- Etiology?
8- Any medication to treat BPD ?
9- Other treatments ?
"Borderline individuals are the psychological equivalent of third-degree-burn patients. They simply have, so to speak, no emotional skin. Even the slightest touch or movement can create immense suffering." Marsha Linehan
Prevalence:

1-3% (to 5.3%) general population
(USA =5,873,108)

10% of psychiatric outpatients
20% of psychiatric inpatients.

Diagnostic Criteria for BPD (301.83)

- Fears of abandonment
- Unstable intense interpersonal relationships
- Identity disturbances
- Self-damaging impulsivity (e.g., spending, sex)
- Recurrent suicidal or self-mutilating behavior
- Affective instability
- Feelings of emptiness
- Inappropriate intense anger
- Transient paranoia or dissociation

DSM-IV, 1994
Clinical Features

Phenomenology

- Emotion dysregulation;
- Cognitive dysfunction;
- Dissociative states; perceptual alteration; temporary malfunction of reality testing.

BPD- 1- Behavioral Symptoms

- Poor affect regulation.
- Poor impulse control.
- Unstable relationships.
- Risky behaviors.
- Self harm.
- Suicidality.
BPD-2 - Cognition

Problems with:

- Attention
- Memory
  - working memory
  - declarative memory
  - procedural (implicit) memory
- Learning processes
- Executive functioning
- Social cognition (emotion recognition, interpretation of emotion, mentalization/Theory of Mind [TOM])

BPD- 3- Cognition/Perceptual alterations

富民 in reality testing (paranoid experience, hallucination, magical thinking etc).

75% meet criteria for remission after 6y//10y years (Zanarini et al. 2003//2007)
- 60-75% after 20 y F/u no longer meet criteria for BPD, were doing relatively well and able to live independently.

10% completed suicide
- 36%, among these who met 8 DSM criteria, completed suicide (compared to 7% who met 5-7 criteria).
BPD: Etiopathology/Risk & Vulnerability


- neglect
- trauma (sexual, physical abuse)
- chaotic-disorganized

HPA axis hypersensitivity (Figueroa & Silk 1997; Rinne et al. 2002).

Neurotransmitter Systems

**Serotonin** (Coccaro, Siever et al. 1989; Figueroa & Silk 1997).

**Dopamine** (Friedel 2004).

**NMDA receptors dysfunction** (Grosjean & Tsai 2007).
Borderline Personality Disorder: Neuroimaging

- FMRI of BPD patients listening to scripts describing abandonment events show dysfunction of **medial and dorso-prefrontal cortex**. Schmal et al. 2003.
- Pain produced neural deactivation in the perigenual anterior cingulate gyrus (ACC) and the amygdala in patients with BPD. Schmahl et al. Arch Gen Psychiatry. 2006
- Abnormal **insula response** compared to healthy participant in task testing interpersonal cooperation skills. King-Casas et al. Science August 2008
Main Points:

When establishing BPD diagnosis pay attention to:

• Past and present symptoms in the 3 dimensions: behavioral, affective and cognitive
• History (personal and familial, social and psychiatric)
• Type of relationships established in and out therapy (object relation/transference; counter transference)
• Response to treatments (pharmacological and psychotherapeutic)
Psychotherapy

- **Kernberg: Transference Focused Psychotherapy**
  - Object relation model

- **Linehan: Dialectic Behavioral Therapy (DBT)**
  - Deficit in self regulation
  - Invalidating environment

- **Bateman & Fonagy: Mentalization Based Treatment (MBT).**
  - Importance of attachment; mentalization

- **Jeffrey Young Shema Therapy**
Pharmacologic Treatment in Borderline Personality Disorder

- SSRI (antidepressant)
- Antipsychotics (low dose)
  - Mood stabilizers
  - Anxiolytics

- Polypharmacy is the (bad) rule rather than the exception
PSYCHOTHERAPY BASICS
• PROVIDE STRUCTURE
• BE MATTER OF FACT. Calmly address affect-laden issues. Avoid expression of extreme emotions
• HELP PATIENTS TO VALIDATE THEIR OWN EXPERIENCE by acknowledging their feelings while also CLEARLY STATING THE EXPECTATION OF BEHAVIOR CONTROL
IN CRISIS: self-soothing, grounding, distraction

• Basics to intervening when someone is in distress
• Goal is to de-escalate emotional intensity before problem solving
• Breathing, “emotional recess”, naming item in the room, stroking an animal, coloring, singing a song
• Validation - wants to be understood rather than understand
When things are calmer

• Developing plan for crisis when patient are not in crisis
• Discuss validation, distraction and soothing strategies
Do not forget!

- Everyone’s safety always primary
- Identify signs when hospital is needed
- Reduce access to means
- Identify supports and their purposes
- Involves support network
- Acknowledges own feeling to yourself
- Utilize your network to discuss feelings
- Use consultation opportunities to develop new ideas strategies, and to obtain validation for yourself.
You have to be...

• What you are told you are, whilst not being what you are perceived to be (do not let projective identification win!)
• Calm under fire
• Able to decrease arousal
• Reliable and consistent; doing what you have agreed to do
• Accept that you make mistakes and recognize enactment
• Inquisitive and curious rather than aloof and single minded
• Simple rather than clever

Thank You 😊

- [Image of book cover](image)

- [Website](www.bgrosjean.com)
Post - Test

1- Three words to define BPD?
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3- Difference in BPD prevalence between men and women?
4- % remission after 10 years?
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10- Three important qualities to be able to work with BPD?
Post-Test with answers

1- Three words to define BPD?
   - Emotion Dysregulation
   - Behavioral Dysregulation
   - Cognitive alterations

2- Prevalence BPD? 1.5-3% >18 y/o
   - Schizophrenia? 1.1% >18 y/o
   - Bipolar? 2.6% >18 y/o

3- Difference in BPD prevalence between men and women? NO

4- % remission after 10 years? 70%

5- % successful suicide? 10%
Post-Test with answers

6- Neuroimaging specific for BPD? Yes
7- Etiology? Mix of genetic vulnerability and stressful environment (chaos/abuse/neglect)
8- Any medication to treat BPD? No only to alleviate some symptoms
9- Other treatments? TFP DBT MBT
10- Three important quality to be able to work with BPD? Being aware and in control of counter transference; ability to be empathetic AND to set firm limits; good ability to translate emotion and acting out in non threatening language
Bipolar 1 and 2 have **19.4% comorbidity** with BPD and 7.9% for all the other type of personality disorder.

Gunderson (2006)
Main points

• Trying to distinguish these two conditions is difficult because they share so many characteristics

• 3 possible diagnosis:
  – Bipolar only
  – Borderline PD only
  – BPD with BP

• The treatments to be considered are at time similar and require a subtle blind of suppleness and firmness
Common symptoms

- Rapidly changing moods of depression, irritability, grandiosity, pressured speech, racing thoughts, etc.
- Poor relationships
- Difficulties with concentration and focus
- Difficulties with task completion
- Impaired judgment and impulsivity
- Disorganization
- Becoming overwhelmed with stressful situations
- Psychotic Symptoms
Differential diagnosis

• Can only be made over time
• Clinician need to be flexible and avoid to be rigid about the diagnostic label.
How are Bipolar and Borderline Personality Disorder Different?

• In **BPD**, mood changes are often more **short-lived** -- they may last for a few hours at a time.

• In contrast, mood changes in bipolar disorder tend to **last for days or even weeks**.
How are Bipolar and Borderline Personality Disorder Different?

- Mood shifts in BPD are usually in reaction to an environmental stressor (such as an argument with a loved one), whereas mood shifts in bipolar disorder may occur out-of-the-blue.
- Mood shifts typical of BPD rarely involve elation -- usually the shift is from feeling upset to feeling "OK," not from feeling bad to feeling a high or elevated mood, which is more typical of bipolar disorder.
How are Bipolar and Borderline Personality Disorder Different?

• In BPD:
  – auditory hallucinations that are intermittent and related to stress are recognized as hallucination.
  – no fixed paranoid delusions
  – feelings of “being unreal” are often related to stress

• In psychosis (schizophrenia/SAD) hallucinations are not identified as such, presence of fixed delusion, feelings of being “unreal” are infrequent
BPD

- **Cognitive**
  - unstable self
  - transient paranoid ideation
  - chronic emptiness
  - abandonment
  - fear

- **Poor impulse control**
  - (sex, substances, self-harm)

- **Mood**
  - affective instability
  - reactive mood
  - episodic dysphoria
  - irritability, intense anger
  - anxiety

- **Behavior**
  - suicide attempts (~10%)
  - self-harm
  - Completed suicide (~10%)

Bipolar

- **Cognitive**
  - unstable self
  - psychosis, esp. paranoid/grandiose

- **Poor impulse control**
  - (spending, sex, substances, risk sports)

- **Mood**
  - affective instability
  - "rejection hypersensitivity"
  - dysphoria
  - irritability, intense anger
  - anxiety

- **Behavior**
  - suicide attempts (~10%)
  - self-harm
  - Completed suicide (~10%)