

# **BPD for Professionals, Patients and Family Members**

## ***Overview for NEA.BPD***

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# Diagnosis, Epidemiology, Biology

# *BPD Criteria*

- Interpersonal Hypersensitivity
  - Abandonment fears
  - Unstable relationships (ideal/devalued)
  - Emptiness
- Affective/Emotion Dysregulation
  - Affective instability (no elations)
  - Inappropriate, intense anger
- Behavioral Dyscontrol
  - Recurrent suicidality, threats, self-harm
  - Impulsivity (sex, driving, bingeing)
- Disturbed Self
  - Unstable/distorted self-image
  - Depersonalization / paranoid ideation under stress



# *Clinical Presentation*

- If the patient feels cared about:
  - Appears as a depressed waif
- If the patient feels threatened:
  - Appears angry, with self-injury
- If the patient feels alone:
  - Appears/feels desperate, impulsive, or disconnected

# *Myths about BPD*

1. Unwise to share diagnosis
2. Cannot diagnose in an acute setting
3. Can treat comorbid Axis I disorders effectively without treating BPD
4. BPD patients try to defeat therapists
5. Patients with BPD do not improve
6. I have to know DBT to treat BPD

# *Taking a History*

- Are symptoms triggered by interpersonal stress (i.e., breakups)?
- Is the depression “treatment resistant”?
- Does the patient self harm? (And what is the function of the self harm?)
- Are relationships unstable?



# RESPONSES TO DIAGNOSIS OF BPD

(N = 30)



# *Basic Epidemiology*

- Prevalence
  - Roughly 20% of clinical samples
  - 1.2 - 5.9% of the general population
- Gender
  - Approximately 75% female in clinical samples
  - More equal M:F ratio in community samples



# *Make the Diagnosis*

- In an outpatient sample 2 of 61 patients were actually given the diagnosis

Zimmerman 1999

- 40% of patients who do have BPD and do not have bipolar disorder have previously been *inaccurately* diagnosed with bipolar disorder

Zimmerman 2010

- Comorbid depression does not effect the accuracy of BPD assessments

Morey 2010

# *Heritability / Familiarity*

- Among 92 identical and 129 fraternal twins
  - Genes accounted for 69% of the variance in diagnostic concordance
- Across 9 family studies
  - 12.6% of first-degree relatives of BPD probands had BPD
  - 4X higher than non-BPD probands

# *Heritability*

Schizophrenia	85%
Bipolar	80%
ADHD	75%
<b>BPD</b>	<b>68%</b>
MDD	45%
Panic Disorder	40%
PTSD	30%



# Course and Outcome

# *Suicidality and Self-harm*



- 65-70% of persons with BPD make at least 1 suicide attempt
- 10% of patients with BPD complete suicide

*-Black 2004; Oldham 2006*

- Self-injury (cutting, burning, bruising, head-banging, biting) is seen in 75% of pts

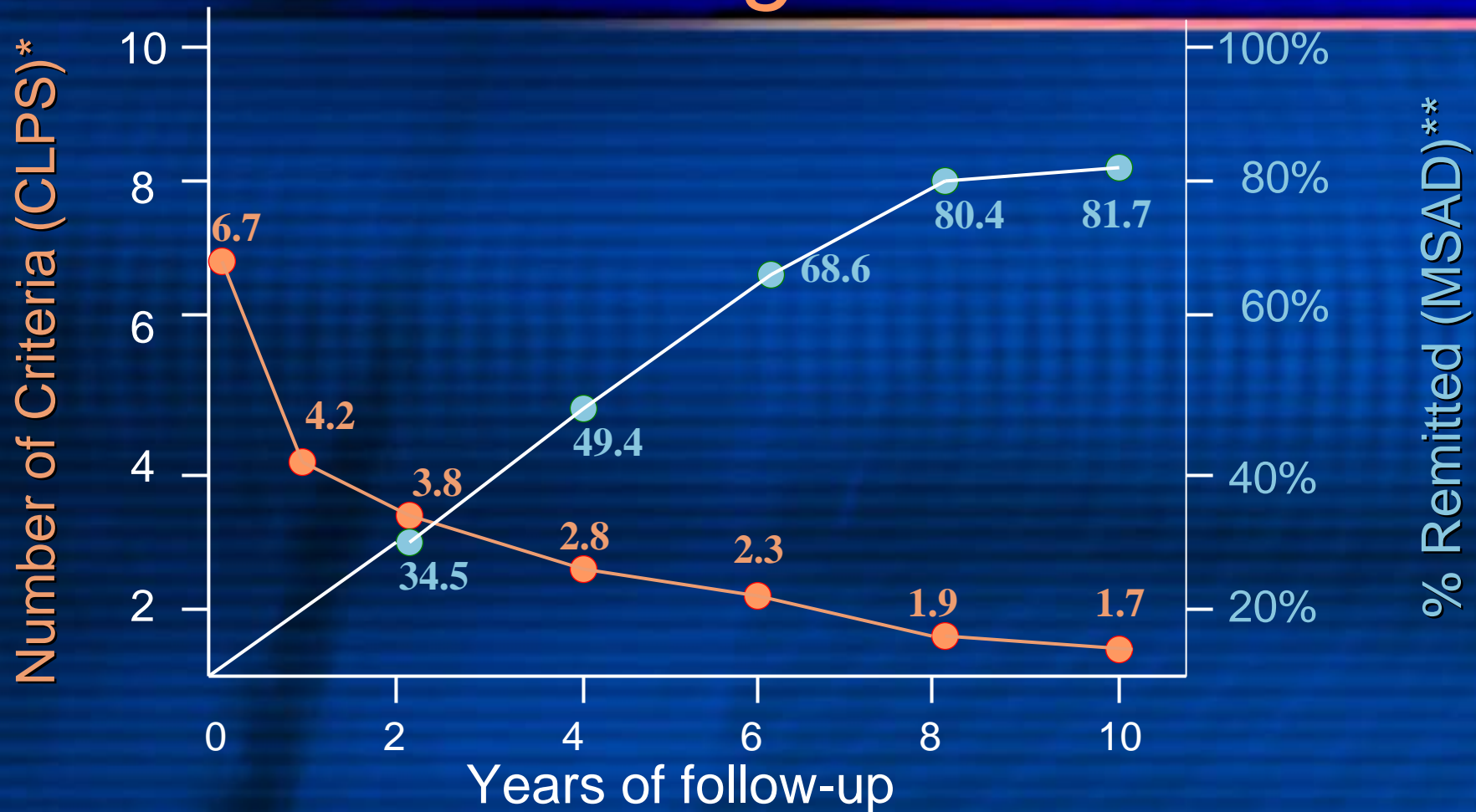
*-Gunderson 2008*

# *Functions of Self-Injury in BPD*

- Feel concrete pain (59%)
- Inflict self-punishment (49%)
- Reduce anxiety/despair (39%)
- Feel in control (22%)
- Express anger (22%)
- Feel something when numb (20%)
- Seek help from others (17%)
- Keep bad memories away (15%)



# BPD's Longitudinal Course



\*From the Collaborative Longitudinal Study of Personality Disorders (Gunderson, *Archives*)

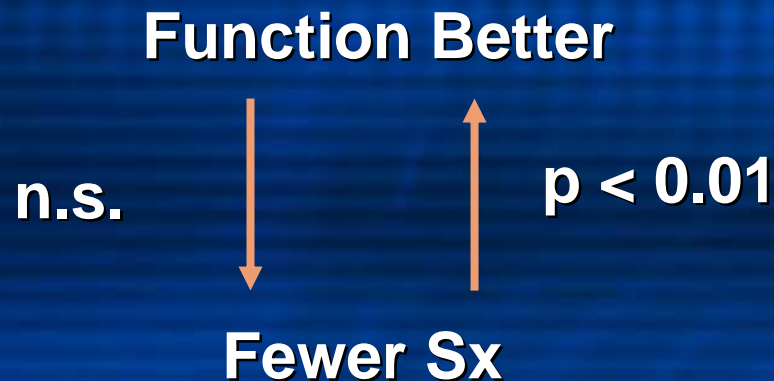
\*\*From the McLean Study of Adult Development (i.e., Zanarini et al. *AJP* 2003; 160:274-283)

# *CLPS Outcomes*

- After 10 years only one third had full-time employment
- BPD has a markedly negative effect on MDD (“treatment resistance” until BPD remits), but MDD had only modest effects on BPD’s course.

# CLPS Outcomes

- Fewer symptoms -> Better functioning





# *Persistence of MDD in BPD*

- National Epidemiologic Survey on Alcoholism and Related Conditions: 40,000 interviews
- 2422 with MDD, 1996 re-interviewed at 3 years
- 15% persisted; 7.3% with recurrence after remission
- Controlling for all Axis I and II disorders, age of onset, number of prior episodes, family history, treatment, and duration of illness, BPD remained the most robust predictor of MDD persistence (OR 2.51 95% CI 1.67-3.77).
- “57% of cases would not have persisted in the follow-up period in the absence of BPD”

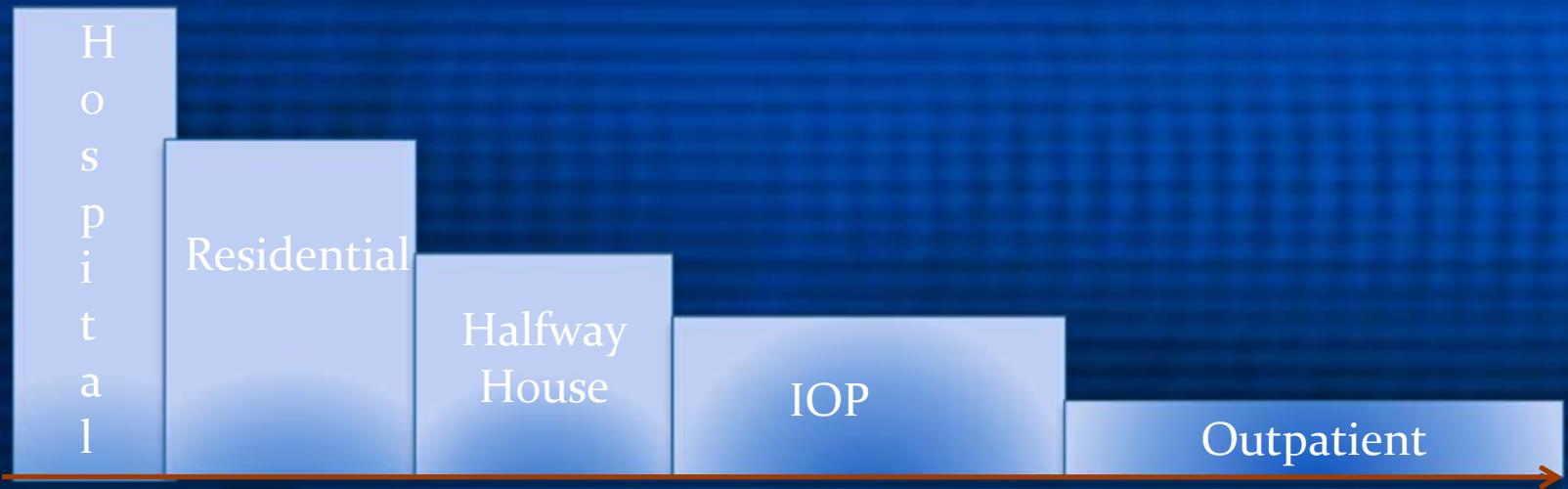
# *Clinical Pearls*

- Most patients with BPD achieve remission
- Impulsive symptoms decline more rapidly than affective symptoms
- BPD negatively affects the course of major depressive disorder (“treatment resistant”)
- Work and social functional impairment persists after symptomatic remission
- Improving either functioning or symptoms predicts improvement in the other domain

# Principles of Treatment



# Levels of Care



Admission

4-6wks

6-36wks

4-6weeks

1 yr+

Makes therapy poss--Basic socialization--Behavioral Change--Interpersonal Growth

# General Considerations

## Dilemmas & Disruptions

*Control struggles and boundary problems*



## Therapeutic Interventions

*Clear goals, expectations, and limits*

Symptomatic bids to test availability and responsiveness of treaters



Supportive but non-reinforcing stance



Non-reactive but careful attention to provocative behaviors

*Splitting*  
*Idealization/devaluation, inconsistent information*



*Consistency and coherence in teamwork*

# *Empirically Validated Treatments*

- Dialectical Behavioral Therapy (DBT)
  - *Linehan et al., 1993, 2006*
- Mentalization Based Treatment (MBT)
  - *Bateman & Fonagy, 1999, 2001, 2003, 2008*
- Schema Focused Therapy (SFT)
  - *Giesen-Bloo et al., 2006*
- Transference Focused Psychotherapy (TFP)
  - *Clarkin et al., 2007; Levy et al., 2006*
- Systems Training for Emotional Predictability and Problem Solving (STEPPS)
  - *Blum et al., 2008*
- General Psychiatric Management (GPS)
  - *McMain et al., 2009 (after Gunderson & Links)*



# *A Spectrum of Approaches*

Cognitive Behavioral

Psychodynamic



DBT

MBT

STEPPS

SFT

TFP

GPM

# *Dialectical Behavioral Therapy*

- Highest number of research studies
- Effective for treatment of suicidal behaviors and substance abuse
- Most available platform for training
- Prepackaged, easily implemented in a broad number of settings

# *DBT- The Approach*

- Dialectics=> mitigate tendencies towards splitting or black and white thinking
- Validation=> clarifies patient's experience and therapist's understanding, promotes stabilization of sense of self, decreases need for behaviors to respond to emotional states
- Acceptance=> non-reactive acknowledgment of way patient is as an adaptive consequence of biology and environmental factors
- Behavioral principles of shaping, reinforcement



# *Mentalization Based Treatment*

- Longest study shows gains in symptom reduction over 8 years
- Simple, general approach that does not require detailed knowledge of skills but a general understanding of a mentalizing process
- Easy to implement in a treatment setting
- Available brief trainings for any discipline

# *General Psychiatric Management*

- Found to be as effective as DBT (McMain et al., 2009)
- Uses APA Guidelines for treating BPD
- Developed after Gunderson (Gunderson and Links, 2008)
- Employed clinicians who had an interest and experience with treating BPD
- Common features with DBT
  - Supervision/Consultation weekly
  - Helping relationship
  - Here and now focus
  - Validation and empathy
  - Emotion focus

## *Common Features of Effective TX*

- Specialized to address BPD
- Structured (groups and individual work)
- Coherent and stable, not reactive
- Contracting
- Crisis plan
- Supervision for managing countertransference
- Therapists are active
- Monitoring progress



# Psychopharmacology

# *A Dilemma*

“We can prescribe antipsychotics, but patients with BPD do not have true psychosis. We can prescribe antidepressants, but patients with BPD do not have classic depression. We can prescribe mood stabilizers, but the affective instability of BPD is not the same as the symptoms of bipolar disorder.”

*-Paris 2008 (p. 113)*

# *Goals of Psychopharm*

Pharmacotherapy often has an important ***adjunctive*** role, especially for diminution of symptoms such as

- affective instability,
- impulsivity, and
- psychotic-like symptoms



# An Engine that fuels...

Mood Symptoms

Anxiety

Substance Abuse

Eating Disorder

Impulsivity



# Key Principles

- 1) Collaborate to determine goals and set accurate expectations  
i.e., decrease mood lability, normalize sleep, decrease transient psychotic symptoms
- 2) Measure the effectiveness of the intervention
- 3) Use a methodical approach to medication trials
- 4) A key goal is to use psychopharm to help the patient engage in psychotherapeutic treatment.

# *Antidepressants*

- MAOI's – moderate effectiveness but lethal in overdose
- TCA's – poor efficacy and lethal in OD
- SSRI's/SNRI's – greater benefit on anger and anxiety than on depressed mood and impulsivity; still a first-line treatment given safety profile and efficacy



# *Antipsychotics*

- First- and second-generation agents can benefit affective (esp anger), behavioral, and cognitive-perceptual symptoms.
- Balance between accepting the risks of these medications (both first- and second-generation) and measuring clear benefits.

# *Mood Stabilizers*

- Affective instability in BPD is different than hypomania or mania and does not respond as well to mood stabilizers
- Mood stabilizers are more helpful with impulsivity and anger than with mood regulation, but there is evidence for anxiety and mood benefits.
- Poor evidence for lithium (absent Bipolar disorder); concerning toxicity

# *Benzodiazepines*

- Alprazolam has shown worsening of symptoms and an increase in severe behavioral dyscontrol
- Benzodiazepines can be disinhibiting and impair already-precarious cognitive functions and should be used with caution

NOTE: Patients with BPD often want to use meds to eliminate - rather than regulate - feeling states (particularly anxiety).



# *Polypharmacy*

- Most patients with BPD are on 4-5 agents, and the side effects, interactions, and treatment effects are difficult to disentangle.
- Adopting a rational, methodical, collaborative approach to psychopharmacologic management can, in and of itself, be therapeutic.
- Careful consideration of starting – and then *stopping* – agents is warranted.

# At a Glance

	Anti- psychotics	Anti- depressants	Mood Stabilizers
Anger	+++	+	++++
↓ Mood	0	0	++
Anxiety	0	+	+++
Impulsivity	+	0	++++
Cognitive- Perceptual	++	0	0
Functioning	+	0	++

*Adapted from Ingenhoven 2010*

# *Psychopharm Pearls*

- Collaborate, set goals, be methodical
- Consider BPD the primary diagnosis



# Family Involvement

# Overview

- Families with BPD struggle with reactions and responses that are similar to those of professionals working with these patients
- Decreasing reactivity is key (by decreasing blame!)
- Family involvement requires structure
- Principles of family work for BPD patients are different than those for other psychiatric patients
- Validation and a focus on effectiveness can make for real change in families

# 1. *Go slowly — change is hard*

- Be cautious about “you can do it” reassurance. Progress evokes fears of abandonment
  - *Experienced hospital staff do not tell borderline patients at discharge that they are hopeful about their prospects; they note many challenges lie ahead.*
- Work in small steps
  - *Set realistic goals that are attainable. Rapid return to college after a hospitalization may minimize the reality of a patient’s struggle.*



## *2. Family Environment: Engage but Modulate!*

- Appreciation is normal, but tone it down.  
Disagreement is normal. Tone it down too.
  - *The key is to decrease blame and judgment, which escalates anger, shame, and fear.*
- Maintain family routines as much as possible.
- Find time to talk. Neutral topics

***“Assuming the worst is  
destructive”***

Marsha Linehan, Ph.D., University of  
Washington, Developer of DBT

### *3. Managing Anger: Pay Attention and Stay Calm*

- Don't get defensive in the face of criticism. Allow yourself to be hurt.
  - *Acknowledge the truth in the point being made, even if the only truth is the patient's experience. Remember that expressing rage with words is preferable to actions.*
- Don't reject accusations or over-personalize them.



## *4. Addressing problems*

- Self-destructive acts require attention.
- When solving a family member's problems, collaborate. Ask them what they can do. Ask what you can do to support/help.
- It is helpful for parents to stay consistent with their strategies.
- If you have concerns about treatment, let your family member and their treaters know.

## *5. Limit Setting – Be Direct but Careful*

- Set limits by stating the limits of your tolerance. Be clear and simple. Waffling promotes problems.
- Do not protect family members from the natural consequences of their actions.
- Limits are NOT coercive control tactics; these will backfire
- Do not tolerate abusive behaviors such as threats, hitting and spitting. Walk away and return to discuss the issue later.

# *Encourage Parental Involvement*

- Professionals: you “share their pain”
- Parents should learn about BPD (readings, lectures, their child’s treaters)
- Parent organizations / support groups
- Advocacy



# *Family Connections*

- Developed by Alan Fruzzetti, Ph.D., and Perry Hoffman, Ph.D. from the National Education Alliance for Borderline Personality Disorder (NEABPD)
- 12 week structured course
- Led by professionals or family members
- Integrates DBT principles of acceptance and mindfulness
- [www.borderlinepersonalitydisorder.com](http://www.borderlinepersonalitydisorder.com)