Borderline Personality Disorder

Dr Christine Dickson, Dr Deanna Mercer

CMHA-Ottawa Jan 27 2016

Changes to BPD in DSM 5

- Section II: No changes at all from DSMIV
- Section III: reflects the past 30 years of research on personality disorders

Personality Disorder

DSM 5 Section II

- Enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture. Manifested in two or more of the following: cognition, affectivity, interpersonal functioning, impulse control
- Enduring pattern that is inflexible, pervasive across a broad range of personal and social situations
- Leads to clinically significant distress or impairment in social, occupational or other important areas of functioning
- Is stable and of long duration, can be traced back to adolescence or early adulthood
- Not better explained by another mental disorder, substance or another medical condition

DSM 5 Section III

- Moderate greater impairment in personality functioning
- One or more pathological personality traits
- Impairments are relatively inflexible and pervasive across a broad range of personal and social situations
- Impairments are relatively stable over time, can be traced back to at least to adolescence or early adulthood
  - Not better explained by another mental disorder
  - Not solely attributable to substance use or another medical condition
  - Not better understood as normal for developmental stage or sociocultural environment

Personality Disorder

DSM 5 Section II

A. Enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture. Manifested in two or more of the following: cognition, affectivity, interpersonal functioning, impulse control

- Cluster A: Schizoid, Schizotypal, Paranoid
- Cluster B: Histrionic, Narcissistic, Borderline, Antisocial
- Cluster C: Avoidant, Dependent, Obsessive Compulsive
- Personality change due to another medical condition
- Other/unspecified personality disorder

DSM 5 Section III

A. Moderate greater impairment in personality functioning (LPFS)

B. One or more pathological personality traits

- Antisocial, Borderline, Schizotypal, Avoidant, Obsessive Compulsive, Narcissistic

OR

- One or more personality disorder traits from Personality Inventory for DSM5
  - Negative Affectivity
  - Detachment
  - Antagonism
  - Disinhibition
  - Psychoticism

BPD in DSM 5

Section II

- Pervasive pattern of instability of interpersonal relationships, self-image, and affects and marked impulsivity, beginning by early adulthood, present n a variety of contexts, 5 or more of:
- Frantic efforts to avoid real or imagined abandonment
- Unstable and Intense interpersonal relationships characterized by alternating idealization and devaluation
- Markedly and persistently unstable self-image or sense of self
- Impulsivity in at least 2 areas that are potentially self damaging: spending, sex, substance abuse, reckless driving, binge eating
- Recurrent suicidal behaviour, gestures, threats, self harm
- Affective instability due to a marked reactivity of mood
- Chronic feelings of emptiness
- Inappropriate or intense anger or difficulty controlling anger
- Transient stress related paranoid ideation or severe dissociative symptoms

Section III

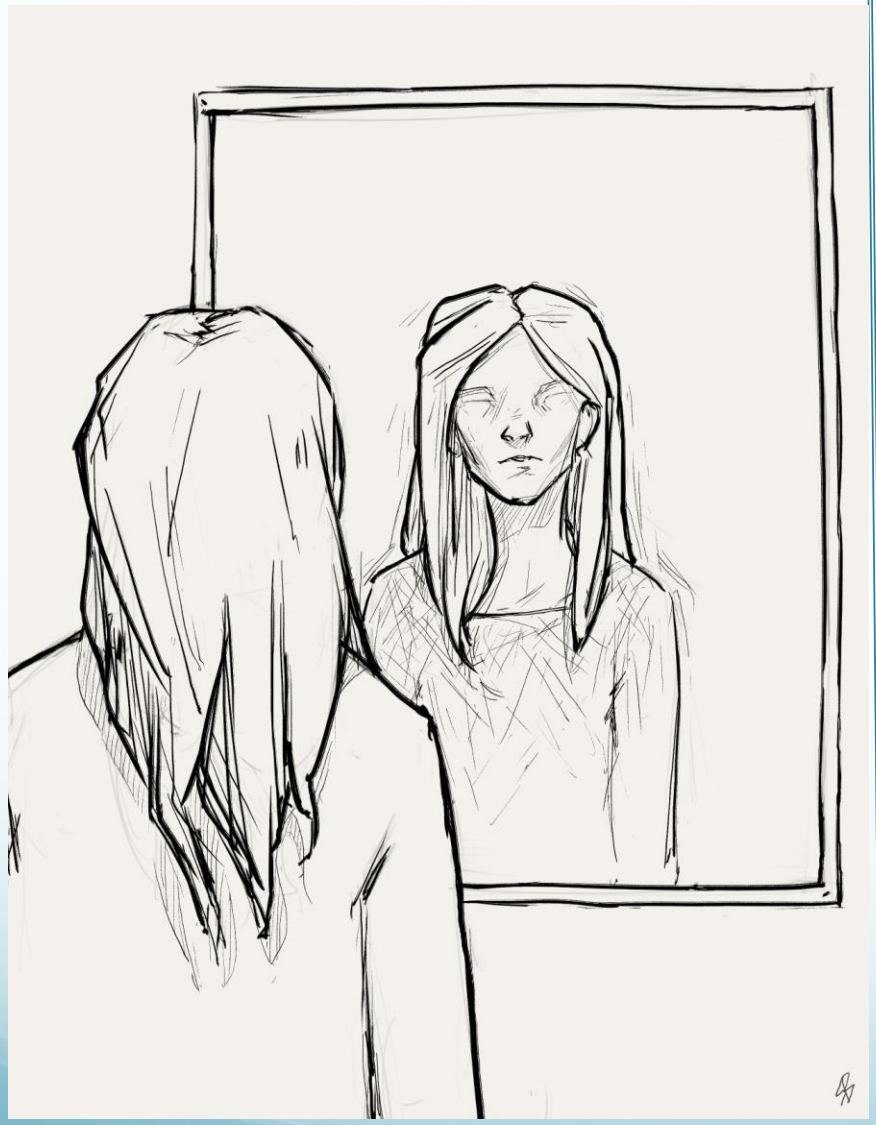
- Identity: impoverished, poorly developed, unstable self image. Associated with excessive self criticism, chronic feelings of emptiness, dissociative states under stress.
- Self Direction: Instability in goals, aspirations, values or career plans.
- Empathy: compromised ability to recognize the feeling and needs of others associated with interpersonal hypersensitivity, perception of others selectively biased towards negative attributes or vulnerabilities
- Intimacy: intense, unstable, conflicted close relationships, marked by mistrust, neediness, fears of abandonment, and extremes of idealization and devaluation and alternating between overinvolvement and withdrawal
- Four or more of: Emotional Lability, Anxiousness, Separation Insecurity, Depressivity, Impulsivity, Risk Taking, Hostility

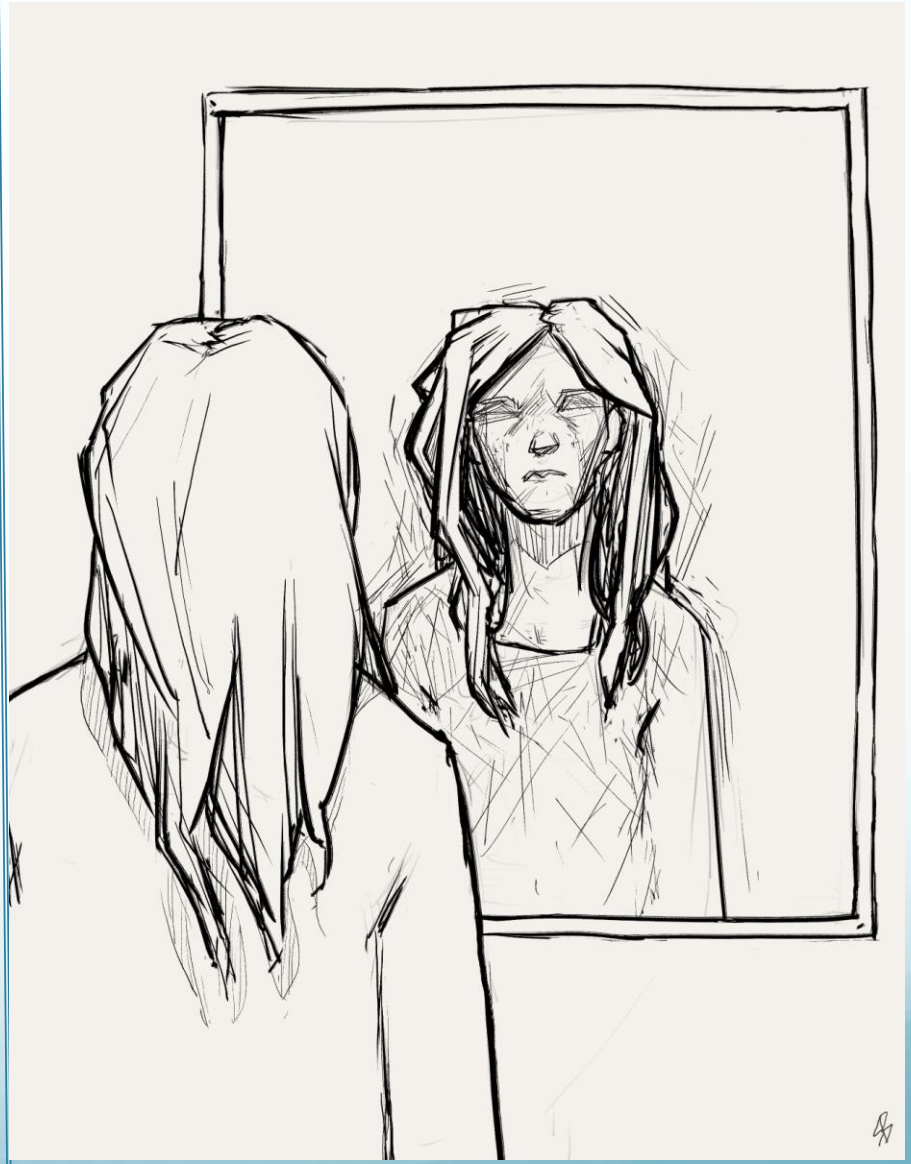
LPFS

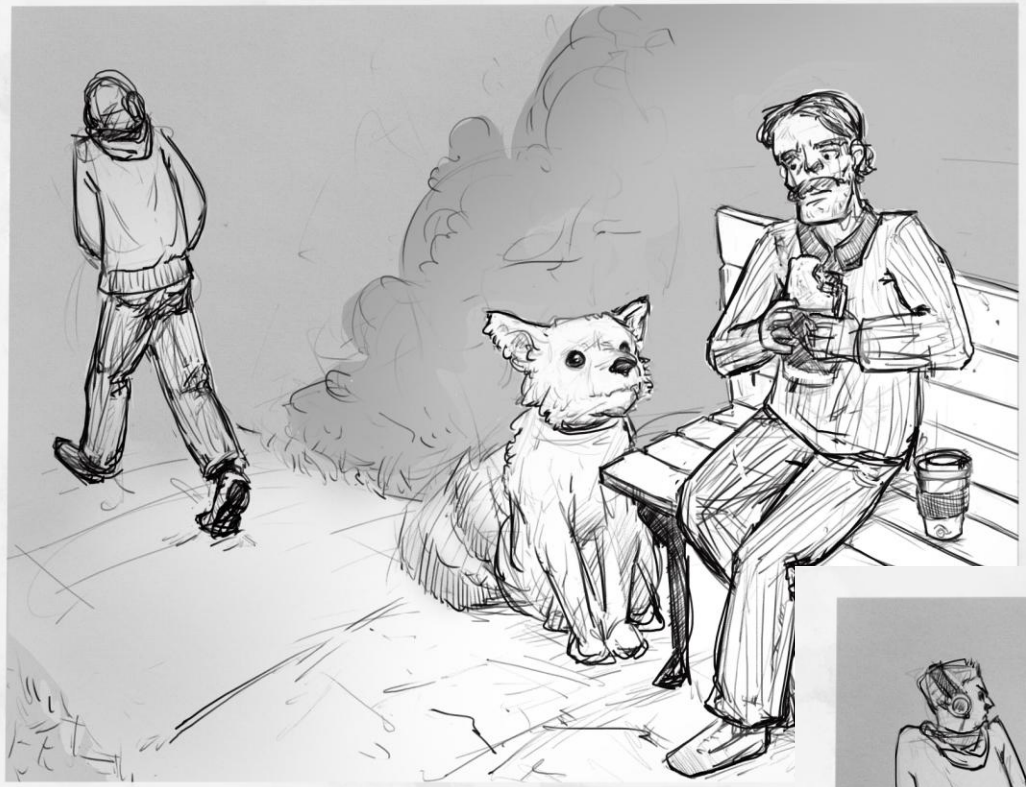
- Moderate impairment in minimum of 2 of 4 areas
- Self
  - Identity: sees self as unique; stability of self esteem, accuracy of self appraisal; experience and regulate emotions
  - Self direction: Ability to set and pursue goals; prosocial internal standards of behaviours; can self reflect productively
- Interpersonal
  - Empathy: understands others experiences and motivation; able to tolerate differing perspectives; understands effect of own behaviour on others
  - Intimacy: Depth, duration, connection with others; desire and has capacity for closeness; behaviour reflects mutual regard in relationships

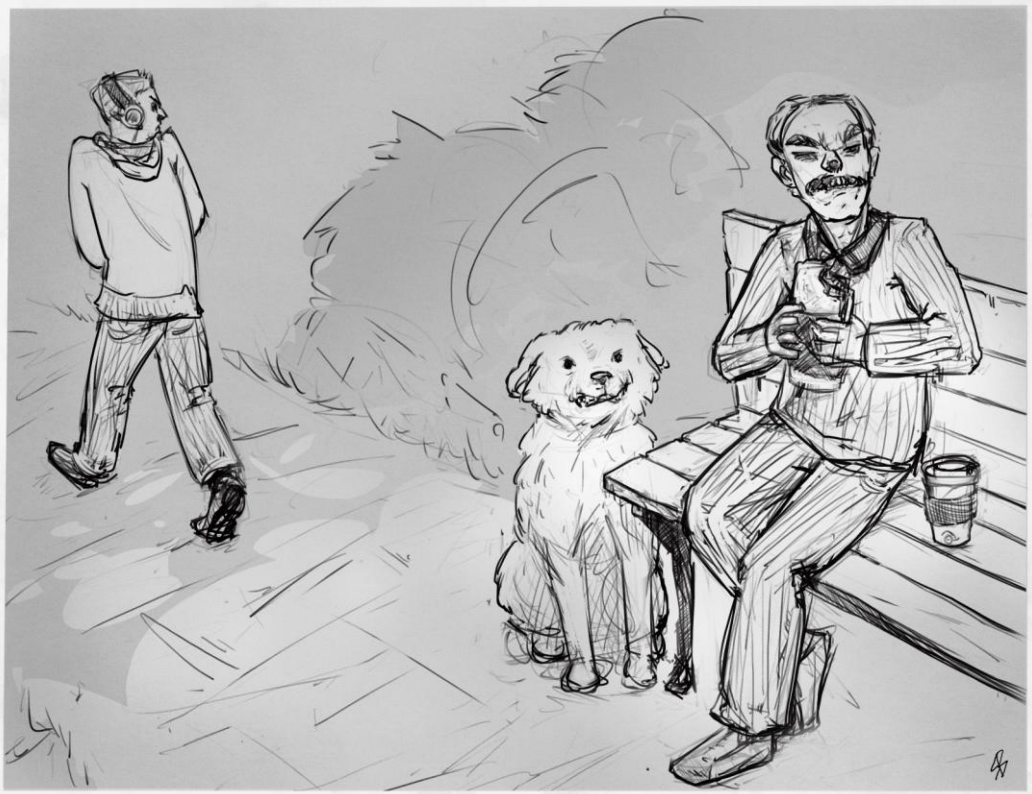
American Psychiatric Association 2013

What is the impact of a personality disorder





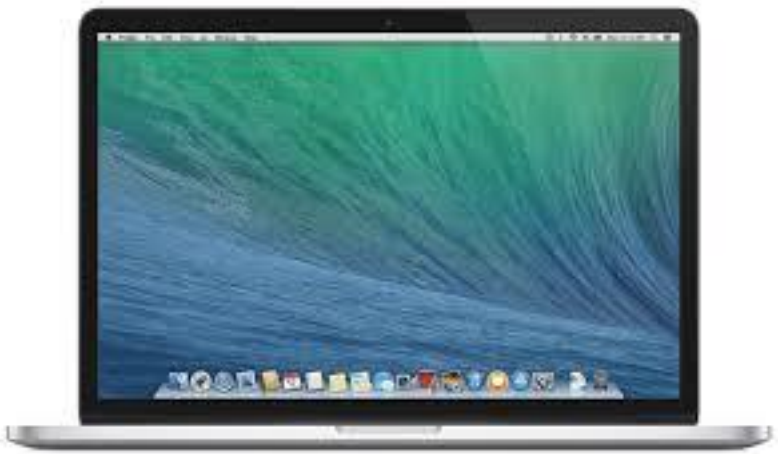


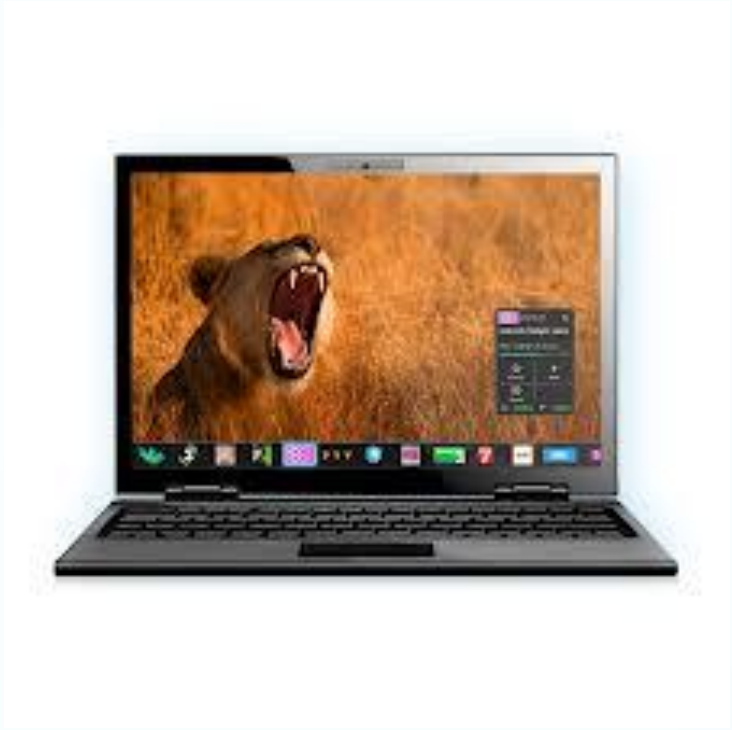


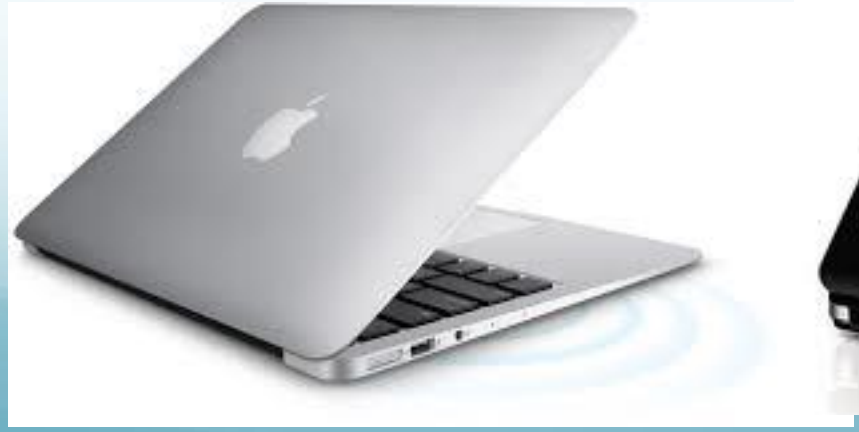
Personality

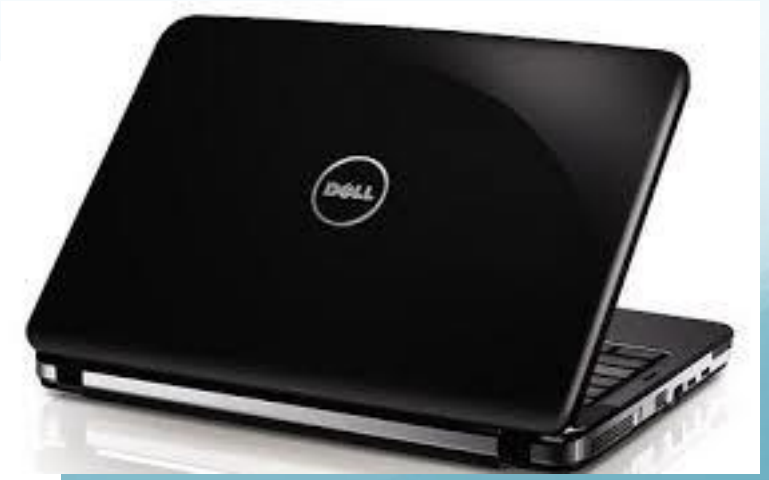
VALUES, GOALS + PERSONALITY TRAITS

NEO PI
Neuroticism
Extraversion
Openness
Agreeableness
Conscientiousness








DELL

BPD Treatment

Comprehensive Psychotherapy

- Dialectical Behaviour Therapy (DBT) n=8
- DBT for BPD+severe PTSD n=1
- Mentalization Based Therapy (MBT) n=2
- Transference focused therapy (TFT) n=2
- Schema Focused therapy (SFT) n=2
- Interpersonal Therapy (IPT) n=3
- CBT n=3
- Client Centered Therapy CCT n=2
- Dynamic Deconstructive Psychotherapy DDP n=1
- **General/Good Psychiatric Management n=1* – *not listed as a separate treatment in Cochrane 2012, was the comparator therapy for DBT in McMain 2010*

Guidelines

- NHMRC 2013
  - R8: people with BPD should be provided with structured psychological therapies that are specifically designed for BPD and conducted by one or more adequately trained and supervised health professionals.
- NICE 2009
  - 5.12.1.3 For women with borderline personality disorder for whom reducing recurrent self-harm is a priority, consider a comprehensive dialectical behaviour therapy program.
  - 5.12.1.2 Do not use brief psychological interventions (of less than 3 months' duration) specifically for borderline personality disorder outside of a specialty program
  - 5.12.1.1 When providing psychological treatment for people with borderline personality disorder, especially those with multiple comorbidities and/or severe impairment, the following service characteristics should be in place:
    - an explicit and integrated theoretical approach used by both the treatment team and the therapist, which is shared with the service user
    - provision for therapist supervision.

Cochrane 2012 Conclusions

- Indications of beneficial effects comprehensive and non-comprehensive therapies for core and associated psychopathology
- *DBT, MBT, TFP, SFT, STEPPS most data
- Findings support a substantial role in treatment of people with BPD
- None of the treatments have a robust evidence base

Is specialist treatment essential?

- Up to 20% of inpatients and 10% of outpatients
- In 4 RCT's designed to show superiority of a specific treatment, control treatments did as well or nearly as well
  - Control treatments were well planned and organized
  - 2 published manuals: Gunderson and Links 2014, Bateman 2013
- Proposed Characteristics for a Generalist Approach
  - Treatment providers have previous experience with BPD
  - Supportive: encouraging, advisory, educational
  - Focus on managing life situations – not in therapy behaviours
  - Once per week, additional sessions as needed
  - Interruptions are expected
  - Psychopharm is integrated, group and family interventions encouraged when needed

Bateman 2015

Medications in treatment of BPD

Clinical Practice

- 1980s – medicalization of psychiatry
- 1980s – only 10% of psychiatrists not using medications in the treatment of BPD

MSAD Zanarini 2004	admission	6 yr F/U
Daily meds	84%	70.8%
Intensive polypharmacy ≥ 3 meds	45.5%	36.7%

- McMain 2010: DBT vs GPM (outpatient)
  - baseline 2.5 meds, 12 months ~ 2meds

Research on Meds for BPD

- Studies are:
  - Small, short term (4-26 weeks)
  - Majority: no patients with suicidal behaviours
  - only a few combine meds with psychotherapy
  - Majority of studies with large effect sizes come from one research centre
- Systematic reviews: meds alone do not lead to remission of disorder

NICE guidelines 2009

- 1.3.5.1 Drug treatment should not be used specifically for borderline personality disorder or for the individual symptoms or behaviour associated with the disorder
- 1.3.5.2 Antipsychotic drugs should not be used for the medium- and long-term treatment of borderline personality disorder.
  - 4 trials largest effect sizes excluded
  - topiramate 3 studies, aripiprazole1 study
  - not able to determine if the trials were funded by drug companies

NHMRC Australia 2012

- Clinical Practice Guidelines for the Management of Borderline Personality Disorder
- Overall pharmacotherapy did not appear to be effective in altering the nature and course of the disorder. Evidence does not support the use of pharmacotherapy as first line or sole treatment for BPD.
- …Reliable evidence based recommendations could not be made about the use of a particular agent to target specific outcomes where fewer than three randomized placebo controlled trials were available for meta-analysis

Cochrane 2010

- Total BPD severity was not significantly influenced by any drug.”
- Findings suggestive in supporting use of second generation antipsychotics, mood stabilizers and omega 3 fatty acids…
- Require replication, since most estimates based on single studies.
- The long term use of these drugs has not been assessed.

Bateman, Gunderson 2015: guidelines for meds in BPD

- Drugs should not be used as primary therapy for borderline personality disorder
- The time limited use of drugs can be considered as an adjunct to psychosocial treatment, to manage specific symptoms
- Cautious prescription of drugs that could be lethal in overdose or associated with substance misuse
- The use of drugs can be considered in an acute crisis situation but should be withdrawn once the crisis is resolved
- Drugs might have a role when a patient has active comorbid disorders
- If patients have no co-morbid medical illness, efforts should be made to reduce or stop the drug
- Adapted from National Health and Medical Research Council (Australia) and National Institute for Health and Care Excellence (UK) Guidelines

Family Guidelines: Multiple Family Group Program at McLean Hospital
John G Gunderson MD Cynthia Berkowitz MD

Table of Contents

Acknowledgement: The Guidelines are adapted from a chapter by the authors, "Family Pschoeducation and Multi-Family Groups in the Treatment of Schizophrenia," McFarlane W. and Dunne B., eds, Directions in Psychiatry 11: 20, 1991. http://www.borderlinepersonalitydisorder.com/wp-content/uploads/2011/08/Family-Guidelines-standard.pdf

PD Prognosis: Studies

- McLean Study of Adult Development (MSAD) Zanarini 2005
  - 362 hospitalized PD patients (290 BPD, 72 other PD)
  - 6 and 10, 20 years.
  - *74% BPD remit by year 6*
- Collaborative Longitudinal Personality Disorders Study (CLPS) Skodol 2005
  - 668 treatment seeking individuals
  - STPD, BPD, APD, OCPD, vs MDD
  - *Remission rates at 24 months 50-64%*
- Children in the Community (CIC) Cohen 2005
  - 1000 families, upper NYState, 700 families at 20 yr F/U
  - Early behavioural disturbance predicts PD in adolescence
  - *Mean PD symptoms highest in adolescence, linear decline 9-27*
  - PD in adolescence predicts ongoing PD in adulthood, Axis I disorders, suicidality, violence and criminal behaviour
- Longitudinal Study of Personality Disorders (LSPD)
  - 250 Cornell U students. 129 at least one PD.
  - F/U 3 points over 4 years
  - *Personality dimensions- significant declines for PD and no PD*

BPD Course

- MSAD 10 year F/U Zanarini 2010
  - Recovery: 50% achieved at least 2 year recovery
  - Remission: 86% at least 2 year remission
    - Recurrence -2 year remission 30%, 4 year remission 15%
      - Recovery: GAF >61, mild symptoms, one emotionally sustaining relationship, participating in FT work/school consistently, competently
      - Remission : no longer meeting criteria for BPD

- What improves? Zanarini 2007
  - "acute symptoms" resolve early <15 % at 10 years
    - Impulsivity; self harm, help seeking suicide efforts,
    - Active attempts to manage interpersonal difficulties: demandingness/entitlement, serious treatment regressions
  - "chronic, trait based" symptoms improve, but 20 – 40% still demonstrating symptoms at 10 years
    - Affective: chronic dysphoria: anger, loneliness,emptiness
    - Interpersonal: abandonment, dependency

BPD Course

- Theories re: improvement over time
  - Maturation- impulsivity decreases with age
  - Social learning- increase skills over time
  - Avoidance of conflictual intimacy –most develop employment, social network but have troubles with intimacy
- Gunderson, Links 2008

Prognosis

- Good prognosis Zanarini 2006
  - < age 25
  - Good school or work functioning in previous 2 years
  - No Childhood sexual abuse
  - No family history substance abuse
  - Low neuroticism, high agreeableness
  - No cluster C (APD does worse, OCPD does better)

Impact of Families

- Family psychoeducation (FPE)
- Family Education programs (FE)

- Some data showing benefits of FPE and FE for family members
- Family involvement, even with high levels expressed emotion, predicted better outcomes for patients with BPD. Hooley, Hoffman Am J Psych 1999
- No data so far on impact of FE on family member with BPD, but our experience is that this has a significant, positive outcome for patients/clients with BPD

Prioritizing treatment

- High co-morbidity with other disorders – mood, anxiety, ED, SUD
- Priority 1
  - Substance Use disorder – dependence
  - ED – anorexia
  - PTSD – severe childhood abuse
  - Mania
- Priority 2
  - BPD
- Priority 3 – these frequently remit with successful treatment BPD, or are much easier to treat
  - MDD
  - Mild substance use disorder
  - Anxiety disorder
  - PTSD
  - Bipolar depression, bipolar II
    - Gunderson and Links 2014

Treatment Options Ottawa/ Gatineau

- Hopital Montfort Hospital French Personality Disorder Clinic
- Hopital Pierre Janet French Clinique Trouble de personnalité limite (TPL)
- tOH Civic English: DBT –Lite Group, Working with Emotions Group, Day Treatment
- CHEO – Youth Program bilingual
- ROHMC – Youth Program English +/- SUD WWE
- CMHA – English
- Social Service Agencies
- Private Practice Options

Hopital Montfort

- Borderline Personality Disorder Clinic (Dialectical Behaviour Therapy Program for Borderline Personality Disorder)

- The Borderline Personality Disorder Clinic runs two separate programs. We offer dialectical behaviour therapy to Francophone adults with a borderline personality diagnosis. This therapy usually lasts 12 months. It centres on teaching skills that enable participants to manage the behavioural, emotional, cognitive and interpersonal effects of borderline personality disorder and to apply the lessons learned in their everyday lives and social interaction. The therapy includes one weekly session of instruction on dialectical behaviour skills (lasting three hours, group open-ended and year round), one private psychotherapy session per week and psychiatric consultations as needed. Our clinic has also created a dialectical behaviour skills group. This 16 to 20 weeks program is designed for a younger clientele (ages 16 to 20) that presents impulsive, harmful behaviour and emotions management difficulties. Throughout the program, these clients also receive weekly private psychotherapy and psychiatric consultations.

- - See more at: http://www.hopitalmontfort.com/en/out-patient-services#borderline

Hopital Pierre Janet

- Guide pour la famille et les proches à propos du trouble de personnalité limite

- http://www.csssgatineau.qc.ca/fileadmin/documents/nos_services/hopital_pierre-janet/depliant_tpl.pdf

Hopital Pierre Janet

- **Critères d'admission**
- Être âgé de 18 ans ou plus
- Être résident de la région 07
- Avoir le diagnostic du Trouble de personnalité limite sévère à l'Axe II
- Ne pas avoir un problème de consommation dont la sévérité pourrait nuire au traitement
- Ne pas être atteint d'une déficience intellectuelle
- **Modalités thérapeutiques**
- Thérapie individuelle hebdomadaire de 60 minutes avec un thérapeute utilisant la TDC
- Groupe d'enseignement et de développement des habiletés de 2 ½ heures/semaine, incluant une pause de 15 minutes, animé par deux co-animateurs (7 places maximum)
- Consultation téléphonique : possibilité de recevoir une assistance téléphonique pour aider à mettre en pratique les habiletés apprises en cas de crise
-

DBT –Lite Program tOH

- This is a 21-week Dialectical Behaviour Therapy Informed Skills group for individuals who have Borderline Personality Disorder or sufficient traits of the condition to be a primary focus of treatment.
- Group members must have ongoing weekly individual therapy
- Patients must be referred by a Mental Health Clinician or Physician in the community or hospital setting who **personally** provides or arranges and supervises the ongoing therapy and any crisis management needed.

DBT –Lite Program tOH

- This is an open group with new members entering every 6 to 8 weeks.
- Total of 8 group members at a time
- Approximately 20 individuals complete the program per year.
- The wait list is currently closed

CMHA

- **DBT Modified:** model of standard DBT group clients with target 1 behaviours have individual therapist
- **DBT-S:** engagement group for individuals with substance use issues
- DBT-DD group: DBT for individuals with developmental delay. Based on Jill Brown's "Skills system" adaptation of DBT.
- **DBT Aftercare Group:** focusing on continual use of DBT skills; meaningful and mindful living; peer facilitation
- **DBT Worker's Group:** required consultation for case managers on DBT skills and strategies in working with and supporting BPD clients.
- **DBT Focus Group:** learning opportunity for staff of DBT skills ,strategies and theory

CMHA

- Groups and treatments available to Clients of CMHA and other Organizations providing Case Management

- Groups are accessible if appropriate and client is receiving Case Management Services

CHEO

- **DBT-A:** 16-week program for youth ages 13-17 with weekly individual therapy, out of session phone coaching, separate youth and caregiver skills training groups., as well as weekly consultation group for staff
- **Caregiver-only group:** 12-week DBT skills training group for the caregivers of youth unable or unwilling to participate in traditional DBT
- **Bridges/Passerelles DBT group:** 12-week DBT skills training group for youth ages 13-17 as part of a community-based intensive outpatient program
- **Research and Action for Teens (RAFT) Study:** Multisite research project involving 12-week DBT skills training group for youth ages 13-19 with concurrent mental health and substance abuse needs

ROMHC

- Youth DBT Program
- Skills group, individual sessions, daytime telephone coaching, and team consultation. It runs once a year late fall until spring for 15 weeks. .
- CENTRALIZED INTAKE CHEO. Physician referral required for youth (ages 16 to 18)
- Adults: Substance Program (SUD) has Working With Emotions Group.

PRIVATE PRACTICE OPTIONS

- A quick scan of e mental Health shows 33 entries under DBT.

A perusal of the Ottawa Academy of psychology includes many entries that indicate DBT is a technique employed. This would suggest that any psychologist who provides DBT is comfortable with the treatment of Borderline Personality Disorder.

PRIVATE PRACTICE OPTIONS

- From experience with the DBT –Lite group I know there are many competent compassionate therapists in the community who have supported the clients in our group. They include psychologists, psychiatrists, MSW's, family physicians. They may be in hospitals, private practice or in Social Service agencies, or in Family Health Teams
- Proposed Characteristics for a Generalist Approach
  - Treatment providers have previous experience with BPD
  - Supportive: encouraging, advisory, educational
  - Focus on managing life situations – not in therapy behaviours
  - Once per week, additional sessions as needed

Treatment Options Comorbidities

- Remember Treatment Staging
- Substance Treatment is crucial if indicated
- Dave Smith Youth Treatment Centre
- Royal Ottawa / Meadow Creek (WWE)
- Rideauwood

Treatment Options

- Community Health /Mental Health Centres
- Social Service Agencies
- YSB
- Remember Treatment Staging and Treating coexisting Conditions

How is BPD diagnosed

- Individuals eventually diagnosed with BPD often seek help for other conditions: depression, anxiety, insomnia, substance use, PTSD.
- BPD may be under-diagnosed and over-diagnosed
- Not everyone with Substance Use, Self Injury or difficulty managing anger has Borderline Personality Disorder. Sometimes expressions of anger are valid and justified and not signs of pathology!
- Some individuals with BPD may not self-injure & do not have extreme overt emotional expression.

How is BPD diagnosed

- In Ottawa Hospitals, Borderline Personality Diagnosis is often made when patients present with suicidal and self injury behaviours, such as frequent self harm, suicide attempts, expressions of suicidal intent. This is coupled with angry affect and signs of interpersonal sensitivity.
- It may be made over the longer term when a mood, anxiety or other disorder does not remit or improve with standard treatments. The clinician may observe difficulties in the therapeutic interactions that suggest the diagnosis.

Can we assess PD's reliably?

- Clinical (unstructured assessments) of personality disorder underestimate the prevalence of PD

  Or overestimate (based on one criteria) the prevalence of PD

  - Zanarini 2000, Zimmerman 2004

- Structured assessments are reliable and reproducible
  - Median inter-rater reliability co-efficients ~ 0.7
  - Short interval test-retest~ 0.5
  - Other areas medicine inter-rater reliability 0.4 – 0.6
  - Other psychiatric disorders inter-rater reliability 0.57 – 0.88

Difficulties in PD Diagnosis

Personality Disorder assessment is one of the most difficult tasks in clinical practice. Practitioners identify the disturbances associated with personality disorder quite accurately, but only record the diagnosis in a few cases”

Tyrer 2015

Clinicians may defer the diagnosis, may diagnose only one PD when more than one is present

They may diagnose PD- NOS

How is BPD diagnosed

- A more reliable BPD diagnosis can be made with a combination of Clinical Impression and a reliable Structured or Semi- structured Interview and/or Questionnaires & Rating Scales.
- Individuals with BPD are diverse (256 possible combinations is often quoted)
- Structured Interviews are lengthy and many clinicians will not undertake them due to complexity and unfamiliarity.

How is BPD diagnosed

INTERVIEWS

- Diagnostic Interview for Borderline Personality Disorder (Zanarini, Gunderson)
- SCID II (structured clinical interview for DSM personality Diagnoses
- NEO P i r(five factor)
- IPDE

How is BPD diagnosed

Rating Scales

ZAN BPD (zanarini)– Measures changes

- Affect – anger/ emptiness/ mood instability
- Cognitive - stress related dissociation, paranoia, identity disturbance
- Impulsivity: including self harm and suicide behaviours
- Interpersonal: abandonment, unstable relationships

Questionnaires

- SCIDII PQ

Under Diagnosis of BPD

- Relying on Clinical Impression without doing a structured or semi-structured interview
- Not using a validated Interview such as Diagnostic Interview for Borderline Personality Disorder(DIB R)
- Gender Bias – assuming males do not have BPD
- Diagnosis may be F:M 3:1. Prevalence is 1:1(Grant 2008)
- Clinician Attitude to BPD / any PD Diagnosis
- Clinician's lack of comfort in treating PD

OVER- DIAGNOSIS OF BPD

- This can occur with reliance on a few symptoms or even on one symptom, without taking into account severity, duration and level of impairment as well as context.

- Not everyone with substance use, self injury or difficulty managing anger has Borderline Personality Disorder

- Remember Categorical vs Dimensional diagnosis

Dimensional vs Categorical Diagnosis

- Regardless of the diagnostic interview, dimensional assessments were consistently more reliable than categorical diagnoses of BPD. Overall, there was reasonably strong support for the reliability of semistructured diagnostic interviews for BPD, although continued work is needed to establish the validity of these instruments. (PsycINFO Database Record (c) 2015 APA, all rights reserved)

- **A systematic review on the reliability and validity of semistructured diagnostic interviews for borderline personality disorder.**

- By Carcone, Dean; Tokarz, Victoria L.; Ruocco, Anthony C.

- Canadian Psychology/Psychologie canadienne, Vol 56(2), May 2015, 208-226

Communicating the Diagnosis

Reasons clinicians don't

- Stigma
- Fear of communicating hopelessness
- Concern about client's reactions

Reasons to communicate

- Improve therapeutic alliance,
- Establish reasonable treatment plans and goals
- Provide relief

Self –Diagnosis

- With social media, on-line support groups, self help work books and the availability of other forms of information and education more individuals question whether they have BPD.

- Having a diagnosis usually brings relief
- If you accept reality, you can begin to change reality