Borderline Personality Disorder: New Insights & HOPE for Recovery

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• How many people work with patients with BPD?

• How many like working with them?

• How many refer BPD patients out?
Most stressful for Mental Health Professional

1. Suicide attempts

2. Threats of suicide

3. Patient anger

Hellman, 1988
• Chronically misunderstood
• Seen as a death sentence
• Seen as untreatable
• Seen as having a poor prognosis
• Seen as under patient’s control
• The Diagnosis is often withheld from patients and families
• “Frequent Flyers”
• “Help-rejecting Complainers”
• “Attention-seeking”
• “Manipulative”
Borderline Personality Disorder & Suicide
Beyond Threats

• **Manipulative, “just threats,”** or **suicide gestures** are terms you may have heard or used to label suicidal thoughts and behavior in individuals with borderline personality disorder.

• These terms **imply that the risk of injury or death is low**, but evidence shows that BPD patients are at high risk for completed suicide—and clinicians who use these labels may underestimate this risk and respond inadequately.
• BPD is the only personality disorder to have suicidal or self-injurious behavior among its diagnostic criteria.

• 65-70% will have at least one suicide attempt

• Suicide rate of 10%—approximately **50 times greater than the general population**.
Recent suicide attempts by individuals with BPD have shown

• the **same degree of lethality** and **intent to die** as recent suicide attempts by individuals without BPD

• **no differences** in degree of intent to die compared with attempts by persons experiencing a major depressive episode or persons with both BPD and depression
• However, patients with BPD (including those with comorbid depression) have reported greater lethality for their most serious life-time suicide attempt than those with depression alone.
General Diagnostic Features

Enduring pattern of inner experience or behavior that deviates from expectations of culture, manifested in two or more of the following:

- cognition (perception of self, others)
  – affectivity (intensity, range of emotions)
  – interpersonal functioning
  – impulse control

Enduring pattern is inflexible, pervasive in many situations
Stated simply,

- Enduring and pervasive patterns of inner experience and behavior that create impairment and distress.
The DSM & Personality Disorders
DSM 5

• Attempt at hybrid dimensional/categorical approach abandoned at the last minute as “too complicated”, but retained in section III for reference

• DSM IV: Axis II but DSM 5 mono-axial system
DSM: Personality Disorder Clusters

• A. “odd and eccentric”- Paranoid; Schizoid; Schizotypal
• B. “dramatic; emotional and egocentric”- Antisocial; Borderline; Histrionic; Narcissistic
• C. “anxious and fearful”- Avoidant; Dependant; Obsessive-Compulsive
Borderline PD

- A pervasive pattern of instability of interpersonal relationships, self-image and affects, and marked impulsivity
- Abandonment issues
- Unstable and intense relationships
- Identity disturbance
- Impulsivity
- Suicidal behavior
- Affective instability
- Chronic feelings of emptiness
- Inappropriate anger
- Transient paranoia or dissociation under stress ("micropsychotic episodes")
• BPD consists of pervasive instability of self-image, affect, and interpersonal relationships.

• This may include impulsive and often self-destructive behavior, unstable and intense relationships, inappropriate and intense anger, and suicidal or self-mutilating behavior.
• 2% point prevalence, 6% lifetime prevalence

• More common in women

• Threats/actions of self-harm are common

• Often viewed as life-long, debilitating condition

• Treatment targets core sxs, especially self-harm
Gender bias in diagnosing personality disorders

- **Antisocial P.D.**
  - Males
  - Females

- **Histrionic P.D.**
  - Males
  - Females

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Percentage of cases</th>
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<tr>
<td>Antisocial personality case</td>
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<tr>
<td>Males</td>
<td>80</td>
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<tr>
<td>Females</td>
<td>40</td>
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<tr>
<td>Histrionic personality case</td>
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<td>Males</td>
<td>30</td>
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<td>Females</td>
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Sex Bias in the Diagnosis of Borderline Personality Disorder and Posttraumatic Stress Disorder (Becker and Lam, 1994)

1. Subjects (n=1,082)
   - Social Workers
   - Psychologist
   - Psychiatrists

2. Procedure
   - Case study with PTSD or BPD symptoms
   - Male and female cases
   - Clinicians rated case studies on a 7 point scale the extent to which a client appeared to have each of the disorders

3. Results
   Clinicians rated female clients higher for applicability of BPD diagnosis than male clients
Psychodynamic origins

• It is theorized that reliance on particular defense mechanisms, such as splitting and projective identification, along with shifts in the emotional experience of self and others, may fuel both the affective and interpersonal problems associated with borderline personality structure.
Biology and BPD

• **Oxytocin**

  facilitates feelings of love and compassion and plays an important role in the development of affiliative motivation and social behavior.
Ebert et al 2017

• Researchers measured plasma oxytocin levels and, on a validated self-report scale, FOC for self, for others, and from others in 57 female inpatients with BPD and in 43 controls

• Compared with controls, BPD patients had lower plasma oxytocin levels (as in previous studies) and scored higher on measures of FOC from others, for self, and for others.

• Within the BPD group only, plasma oxytocin levels were correlated positively with greater levels of recalled parental warmth and negatively with greater FOC from others.
Linehan’s Theory of the Development of BPD

- Based on a bio-social theory of BPD.

Problems w/
1. Ability to understand & label feelings.
2. Coping skills.
3. Emotion modulation.
Stigma & Borderline Personality Disorder

Marginalization of Borderline Personality Disorder
Lewis and Appleby demonstrated that psychiatrists respond unfavorably to clinical vignettes involving the term “personality disorder.”

A similar study involving nurses found that hypothetical patients with BPD received less empathy than those with schizophrenia.
• In a review of this issue, Aviram et al. noted that the *pathology and stigma of BPD can become intertwined*.

• A cycle of self-fulfilling prophecy, in which the behaviors and reactions of patients with BPD evoke certain expectations in therapists

• Aviram et al. noted that potentially stigmatizing responses from therapists include *distancing behaviors, early termination, and rejection from treatment*
“It’s Not a Real Illness”

• This may in part reflect countertransference frustration stemming from clinical experiences with patients with BPD.

• For example, interpersonal or treatment team splitting may sometimes produce feelings of being manipulated, as though such phenomena are completely within the volitional control of the patient.
• Clinical workers may feel bewildered and annoyed when the patient who seemed fine yesterday is now in the throes of a suicidal crisis.

• These fairly rapid shifts in identity and affect may confuse treatment providers so that they view such features as completely voluntary, rather than as complex sequelae of cognitive and emotional dysregulation.
“Chronic and Unresponsive to Treatment”

• Claims that BPD is a lifelong, untreatable disorder are now untenable, and not supported by current research
The Collaborative Longitudinal Personality Disorders Study (CLPS)
The Collaborative Longitudinal Personality Disorders Study (CLPS)

• Used a repeated measures design to follow a cohort of 668 adults representing four DSM personality disorders (including a control group with major depression), over 10 years.

• Evidence from this study suggests that over half of patients with personality disorders achieve some degree of remission after about 2 years.
The Collaborative Longitudinal Personality Disorders Study (CLPS)

- The trajectory of reduced pathology continued, although more gradually, by 10 years

- For majority of individuals, distinct and acute features of the different disorders seemed to remit over time
The McLean Study of Adult Development (MSAD)
• Examined the course of BPD over a 10-year period, drawing from a sample of 290 inpatients.

• Remission was achieved by 88% of the patients, with approx. 40% reaching remission within the first 2 years.
• Clearly, many persons with BPD do experience chronic suffering and protracted functional impairment.

• The CLPS and MSAD research, however, revealed that this is not necessarily to be expected in all cases.
The illness is severe, but the prognosis is GOOD

- Recent 16-year prospective study, n = 290
- Patients followed every two years for 16 years
- Remission = not meeting diagnostic criteria for 2+ years
- After 16 years, **99%** had achieved a **two-year remission**
- **86%** achieved a **4-year remission**
- **78%** had experienced an **8-year remission**
• Of those who achieved recovery, only 34 percent relapsed

• Of those who achieved a two-year remission of symptoms only 30 percent had a symptomatic recurrence

• Of those who achieved a sustained remission at four years, only 15 percent experienced a recurrence

• “The high rate of sustained symptomatic remission and the low rate of symptomatic recurrence after sustained remission are among the most optimistic findings about borderline personality disorder reported to date”

American Journal of Psychiatry
Adolescents & BPD

• Most adolescents diagnosed with BPD will no longer meet the diagnostic criteria when they reach adulthood

• Studies have demonstrated that 2/3 of teens diagnosed with BPD will not meet the diagnostic criteria within a few years

• Community study of self-reported symptoms also found a decrease in rates of BPD diagnosis from 14 to 24 years of age, with significant reductions in symptoms at each 2- to 3-year interval throughout the 10-year follow-up

Treatment and Borderline Personality Disorder
• Systematic reviews and meta-analyses of treatment studies have established a base of support for the treatability of BPD via well organized psychotherapy approaches.
The effectiveness of psychodynamic therapy and cognitive behavior therapy in the treatment of personality disorders: A meta-analysis. American Journal of Psychiatry
Meta-analysis

• Studies of psychodynamic therapy and cognitive behavior therapy that were published between 1974 and 2001 were collected.

• Only studies that
  – 1) used standardized methods to diagnose personality disorders,
  – 2) applied reliable and valid instruments for the assessment of outcome
  – 3) reported data that allowed calculation of within-group effect sizes or assessment of personality disorder recovery rates were included.

• Fourteen studies of psychodynamic therapy and 11 studies of cognitive behavior therapy were included.
Results?

- There is **strong evidence** that both **psychodynamic therapy** and **cognitive behavior therapy** are effective treatments of personality disorders.

- Psychodynamic therapy yielded a large overall effect size (1.46), with effect sizes of 1.08 found for self-report measures and 1.79 for observer-rated measures.

- For cognitive behavior therapy, the corresponding values were 1.00, 1.20, and 0.87. For more specific measures of personality disorder pathology, a large overall effect size (1.56) was seen for psychodynamic therapy.
Another Literature Review

• Binks et al (2012) *Psychological therapies for people with borderline personality disorder*

• **Searched the following databases:** CENTRAL 2010(3), MEDLINE (1950 to October 2010), EMBASE (1980 to 2010, week 39), ASSIA (1987 to November 2010), BIOSIS (1985 to October 2010), CINAHL (1982 to October 2010), Dissertation Abstracts International (31 January 2011), National Criminal Justice Reference Service Abstracts (15 October 2010), PsycINFO (1872 to October Week 1 2010), Science Citation Index (1970 to 10 October 2010), Social Science Citation Index (1970 to 10 October 2010), Sociological Abstracts (1963 to October 2010), ZETOC (15 October 2010) and the metaRegister of Controlled Trials (15 October 2010). In addition, we searched Dissertation Abstracts International in January 2011 and ICTRP in August 2011.

• **Twenty-eight studies involving a total of 1804 participants with BPD were included**
• Conclusion from review of literature: “Psychotherapy is regarded as the first-line treatment for people with borderline personality disorder”

• Pharmacotherapy (as an adjunct)
  – Cochrane Review (2010): SSRI’s not recommended for as first choice for affective dysregulation & impulsivity, nor low dose antipsychotics for cognitive-perceptual symptoms
Cognitive-Behavioral Treatment of Borderline Personality Disorder

Marsha M. Linehan
DBT & BPD

• Dialectical behavior therapy (DBT), a highly structured intensive outpatient treatment derived from cognitive behavior therapy, has been shown in several studies to reduce the acute suicidal and self-injurious behaviors associated with BPD
Dialectal Behavior Therapy & BPD

– DBT targets emotional regulation, mindfulness, distress tolerance, and development of effective coping skills

– Several studies support the efficacy of DBT in the treatment of this disorder & it’s core symptoms

Dialectal Behavior Therapy & BPD

– Research on DBT has demonstrated that it reduces
  • premature termination from therapy
  • psychiatric hospitalizations
  • Self-injurious behaviors

Therapists’ Dialectical Style

– Accepting of the client as he/she is, but encouraging change.

– Centered and firm, yet flexible when the circumstances require it.

– Nurturing, but benevolently demanding.
Many Effective Psychological Treatment Options

• Psychotherapy (Mainstay):
  – DBT: suicide and affective dysregulation
  – Transference-based psychotherapy
  – Mentalization-based psychotherapy
  – Schema-focussed therapy

  – General Principles
    • Focus on patient-therapist relationship in the “here and now”
    • Utilize transference & countertransference to explore relationship
    • Educate patients to recognize their affective reactions and what triggers them
    • Connect actions with thoughts and feelings, both their own and others
      (Kernberg; 2009)
Mentalization-Based Therapy

- Mentalization-based therapy (MBT), derived from attachment theory and psychoanalysis, has also been demonstrated to be effective in treating serious cases of BPD.

- Participants study were followed for 8 years after treatment was begun and 5 years after completing all treatment.

- Participants were found to have **sustained improvements** in **virtually all major areas**.

Mentalization-Based Therapy

- MBT’s effectiveness has also been demonstrated in a less intensive outpatient setting.

- **Substantial improvements** were observed in both conditions across all outcome variables.

- Patients randomly assigned to MBT showed a steeper decline of both self-reported and clinically significant problems, including suicide attempts and hospitalization.

- **CONCLUSION**: “Structured treatments improve outcomes for individuals with borderline personality disorder”.

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Many Psychological Treatments to choose from

• Another psychoanalytically oriented therapy, transference-focused therapy (TFP) has also been found effective, not only in its effects on the clinical features of BPD, but also on attachment patterns—also thought of as the core personality—of patients treated with TFP.

• Study: examined three yearlong outpatient treatments for borderline personality disorder: dialectical behavior therapy, transference-focused psychotherapy, and a dynamic supportive treatment.
• Individual growth curve analysis revealed that patients in all three treatment groups showed significant positive change in depression, anxiety, global functioning, and social adjustment across 1 year of treatment.

• Patients with borderline personality disorder respond to structured treatments in an outpatient setting with change in multiple domains of outcome.

Evaluating three treatments for borderline personality disorder: A multiwave study. Am J Psychiatry
• Other therapies, such as schema-focused therapy (SFT) and systems training for emotional predictability and problem solving (STEPPS) are also showing tremendous promise in the treatment of BPD
Treatment of BPD

– A separate study compared a **cognitive** approach to a **psychodynamic** approach to treating BPD

  • Data was collected **every three months**, for **3 years**

– The study utilized, among other outcome measures,
  • Borderline Personality Disorder Severity Index (BPDSI-IV)
  • Working Alliance Inventory (WAI)
Treatment of BPD

– As expected, most patients improved in response to treatment
– The study utilized, among other outcome measures,
  • Borderline Personality Disorder Severity Index (BPDSI-IV)
  • Working Alliance Inventory (WAI)
– The authors reported that:
  • “Growth of the therapeutic alliance during the first year of therapy represents an important therapeutic mechanism by which a later reduction of borderline personality disorder pathology is facilitated”.
Treatment of BPD

– The authors further conclude that the results of the study:

• “enlarges our understanding of the causal role of the therapeutic alliance in the treatment of different psychiatric disorders”.

– Additionally,

• “In the more semi-structured and long-term treatment of personality disorders, the development and maintenance of the therapeutic alliance constitutes a central issue of therapy and may constitute a central curing mechanism”

Psychiatrists can be very effective

• Study comparing DBT with “general psychiatric management” (the cornerstone of which was psychodynamic therapy) showed positive outcomes for both treatments.
Treatment of BPD

– Both groups had a reduction in general health care utilization, including emergency visits and psychiatric hospital days, as well as significant improvements in
  • borderline personality disorder symptoms,
  • symptom distress,
  • depression,
  • anger
  • interpersonal functioning

– No significant differences across any outcomes were found between groups.

– “These results suggest that individuals with borderline personality disorder benefited equally from dialectical behavior therapy and a well-specified treatment delivered by psychiatrists with expertise in the treatment of borderline personality disorder”

What about Humanistic Therapy & Borderline PD?

• DBT vs. Person-centered therapy in a community mental health clinic

• Both therapy conditions were provided by the same therapists

• That is, therapists alternated between providing the PCT condition for one group of clients and the DBT condition for the other group

• PCT was offered as a **supportive therapy control condition**
The Person-Centered Approach...“provided patients with a safe **therapeutic environment and accurate empathic reflection only**”

- In other words, no bells and whistles
Results?

The PCT condition produced significant gains at both 6 and 12 months on:

- **Parasuicidal, suicidality, and self-harm measures**
- Emotional functioning (including impulsivity, anger, depression, and anxiety measures)
- Global mental health functioning
Which was better, Rogerian or DBT?

- Following analysis, the **helping relationship** ratings were found to account for **as much** variance in **client improvement** as the **differences in treatment** conditions.

- That is, the **impact of the helping relationship** on symptom reduction, including **suicidal ideation and self-harm**, was **more important** than whether the client experienced the PCT or DBT condition.

Linehan has recognized the theoretical parallels between DBT and person-centered therapy:

“I discovered recently that I must have stolen this, unconsciously so to speak, from Rogers whom I had read in the original many years ago. In re-reading him recently, I was stunned at how radical Rogers is”

-Marsha Linehan

(Hellinga, van Luyn, & Dalewijk, 2000, as cited in van Blarikom, 2008, p. 28).
“In my early professional years I was asking the question: How can I treat, or cure, or change this person?”
“In my early professional years I was asking the question: How can I treat, or cure, or change this person? Now I would phrase the question in this way: How can I provide a relationship which this person may use for his or her own personal growth?” ~Carl Rogers
From Nobody Nowhere to Somebody Somewhere

• The term “borderline” originally reflected psychodynamic ideas regarding the “borderland” between neurosis and psychosis, evoking the image of having no real location or definition—belonging “in-between.”

• Marginalization is a process of being shunted to the “margin” or periphery of society. In the system of mental health care, the periphery for persons with BPD is situated “in-between.”
Work is Love Made Visible

- Research findings regarding the etiology, brain pathology, prevalence, course, and treatment of BPD has been slow in reaching the level of Behavioral Health Providers.

- Contemporary understanding of the disorder has progressed considerably since then, but the “in-between” or marginal status of BPD lingers on.
Work is Love Made Visible

• Clinicians too, under the sway of countertransference reactions and general social stigma, may not fully appreciate both the complexity of the disorder and the potential of treatment to ameliorate suffering for those afflicted by it

• Patients with BPD thus remain sidelined, deprived of opportunities for recovery, and therefore deprived of opportunities to disprove stigmatizing and marginalizing attitudes
In summary, awareness of the variable course and potential for treatment response of BPD can not only inspire hope in patients and their families, but it may also relieve anxiety among service providers and helping professionals who tend to see this population as chronically unwell.
The Syndrome of the Wrist Cutter

Abstract

Many hospitals are experiencing an influx of patients who have made several suicide attempts through wrist slashing. A study was undertaken to learn the possible causes of such behavior. It suggested that the wrist slashers have a common behavior pattern stemming from early maternal deprivation and imbedded in inability to give and receive meaningful verbal communications. Therapy is directed at fostering more mature methods of giving and receiving love.
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Many hospitals are experiencing an influx of patients who have made several suicide attempts through wrist slashing. A study was undertaken to learn the possible causes of such behavior. It suggested that the wrist slashers have a common behavior pattern stemming from early maternal deprivation and imbedded in inability to give and receive meaningful verbal communications. Therapy is directed at fostering more mature methods of giving and receiving love.
Time to Move On