

Wisconsin Public Psychiatry Network Teleconference (WPPNT)

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**Working with People Diagnosed with
“Borderline Personality Disorder”**

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“Borderline Personality Disorder?”

1. What is it?
2. How can we be useful to people who have it?
3. Crisis intervention and the role of hospital
4. The role of medication

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Borderline Personality Disorder

**Prevalence of BPD in general population:
8 published studies (Torgersen in press)**

Median 1.42 %, mean 1.16 %

Estimated

10-20 % in Psychiatric Outpatients

15-20 % in Psychiatric Inpatients

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**We react negatively to the “borderline”
diagnosis**

“Having that diagnosis resulted in my getting treated exactly the way I was treated at home. The minute I got the diagnosis people stopped treating me as though what I was doing had a reason.”

Judith Herman
Trauma and Recovery

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Personality Disorder

- A. Pervasive, persistent maladaptive behavior**
 - Not attributable to Axis I
 - Medical illness
 - Or cultural role difficulties.
- B. We all have different ways of protecting ourselves**
- C. We all have bits and pieces of effective as well as maladaptive behavior**
- D. Any label gives very incomplete information**

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Personality Disorders: DSM IVTR classification		
Cluster A: odd or eccentric	Cluster B: dramatic, emotional or erratic	Cluster C: anxious or fearful
<ul style="list-style-type: none"> • Paranoid • Schizoid • Schizotypal 	<ul style="list-style-type: none"> • Antisocial • Borderline • Histrionic • Narcissistic 	<ul style="list-style-type: none"> • Avoidant • Dependent • Obsessive-compulsive

DSM 5 Criteria for Borderline Disorder (American Psychiatric Association, 2013)
<ol style="list-style-type: none"> 1. Avoidance of abandonment 2. Unstable, intense interpersonal relationships 3. Identity disturbance 4. Potentially self-damaging impulsiveness 5. Recurrent suicidal or self-mutilating behavior 6. Affective instability 7. Chronic feelings of emptiness or boredom 8. Inappropriate intense anger/problems controlling anger 9. Transient paranoid ideation or severe dissociative symptoms

Borderline Personality Disorder

I was diagnosed with BPD about 2 years ago. I'm not sure if I really agree with it, but I guess I do fit into the criteria, just not the stereotype. I think that almost everyone on earth could fit into the BPD criteria somehow though. I didn't feel bad about the diagnosis until I started reading about it. Then it seemed to be this horrid curse that labeled me a self-centered, attention-seeking jerk. I don't see myself this way. I hope I am not.



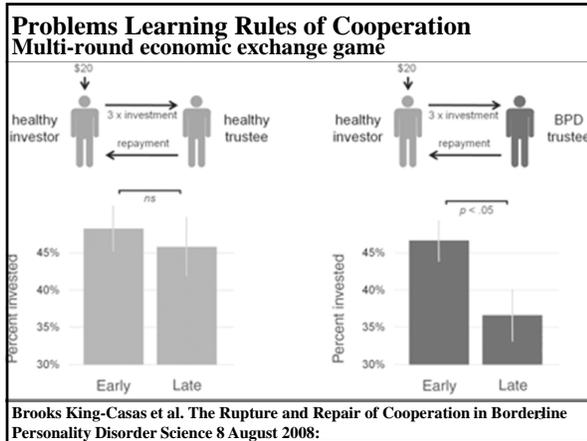
Core Deficits in People with Borderline Disorder

- A. Affective Instability
- B. Impulsivity and low frustration tolerance
- C. Sense of self as being damaged/defective/not good
- D. Difficulty maintaining their own sense of identity/poor object constancy
- E. Poor understanding of rules of normal interpersonal relationships

Failure of Frontolimbic Inhibitory Function in the Context of Negative Emotion in Borderline Personality Disorder

- Decreased ventromedial prefrontal activity
[Decreased ability to inhibit emotion and behavior]
- Increased amygdalar-ventral striatal activity
[Increased negative emotions]

Silbersweig et al Am J Psychiat Dec 2007



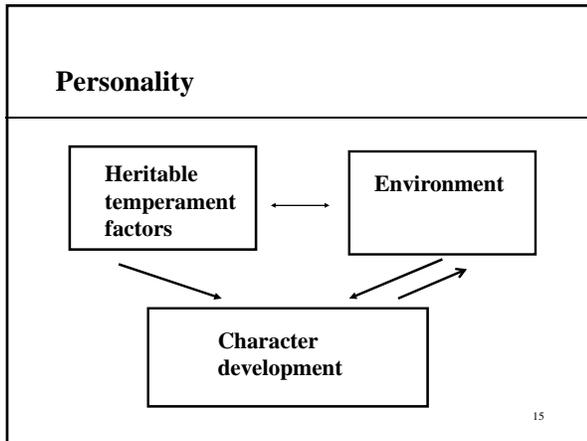
Diary of a Borderline.... raging · posted 11/6/99

Who am I? One day I am a raging violent crazed bitch and the next a sweet, calm young woman. Am I that sex-crazed maniac that rears her head periodically or the depressed shopaholic that keeps me in constant debt?

I dreamed of being successful in my career and well off early in life; I dreamed of having head turning gorgeous looks; Here I am , 25 years old with all I had hoped for, but what good is it all without being happy. I mean , I am

happy SOMETIMES, but for most of the time I feel like an emotional roller coaster.

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Sexual Abuse and Borderline Disorder

- 40-71 % of people with BPD report childhood sexual abuse
- 19-46% of controls also report childhood sexual abuse
- Most abuse survivors do not develop severe adult psychopathology

Zanarini 2000

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BPD and Chronic PTSD

- Intrusive re-experiencing of traumatic event
- Numbing of general responsiveness
- Increased state of arousal

Early history of trauma permanently desensitizes hypothalamic-pituitary axis and may increase risk of developing PTSD

Figuroa and Silk 1997

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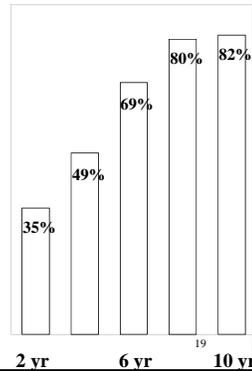
McLean 10 year follow-up study
 Zanarini 2005

- Prospective study with F/U at 2,4,6,8 and 10 years
- N = 362 inpatients with personality disorder
- 290 met DSM III-R criteria for BPD
- 92 % of surviving pts with BPD in 10 year data

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McLean 10 year follow-up study Zanarini 2005

- Almost 90% had remission of BPD
- Recurrence of BPD relatively rare
- 80 % had good psychosocial functioning
- Social functioning less impaired than vocational functioning
- Suicide is substantially less than thought



Course of Symptoms

Zanarini et al Am J Psychiat 2003

Completed Suicide:

3.8 % (N = 11) at 10 year follow up

Course of Symptom Change

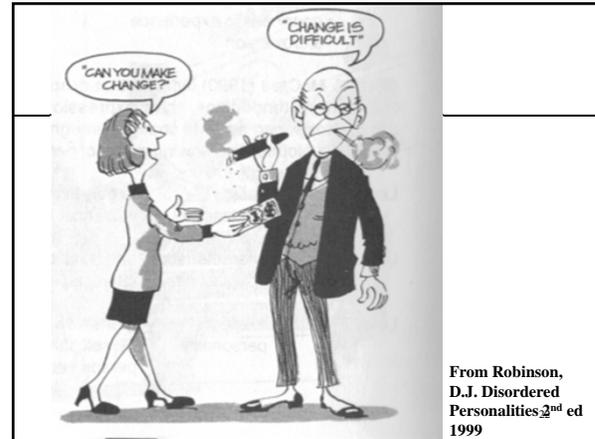
- Affective symptoms decreased least
- Impulsive symptoms decreased most
- Cognitive and interpersonal symptoms intermediate

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“Borderline Personality Disorder?”

2. How can we be useful to people who have it?

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Principles of Treatment

- Educate client and family about the disorder
- Be active, not reactive
- Be thoughtful: model thinking first
- The relationship is real as well as professional
- Convey that change is expected
- Foster accountability
- Focus on life outside of treatment
- Be flexible, pragmatic and eclectic

Gunderson and Links 2014

The goal is to stay in a long term, stable relationship:

- Know the limits of your responsibility
- Be aware of your own feelings
- Monitor and regulate interpersonal distance
- Be aware of "splitting"--being "right" may be less important than being a team

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Significance of a “Healing Relationship”

- 45% of patients identified a significant other as responsible for their improvement
- 29% identified a therapeutic relationship as responsible for improvement

Links and Heslegrave 2000

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Words that Interfere with Relationship

- Manipulative
- Treatment Resistant
- Unmotivated
- Attention Seeking
- Too ill to know what is good for herself

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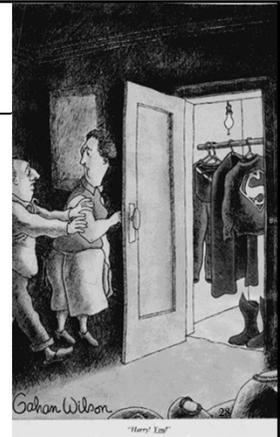
Theoretical Frames Influence our Thinking

- “Fear of abandonment” or
lack of connection and intense isolation
- Repetition of unhealthy relationships, or
constant attempts to connect and poor skill at
“reading” people
- “Chronic chaos” or
powerful drives that overtake the persons
ability to “read” people

Based on personal communications:
Pam Valenta 2002

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Support the client's
own sense of
competence



Supportive Psychotherapy for BPD

Focuses on

- Increasing Self-esteem
- Reducing anxiety
- Enhancing coping mechanisms

– (Pinsker et al)

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Supportive Psychotherapy for BPD

- Conversational but not conversation: goal focused
- Encourages a “real” relationship
- Uses clarification, suggestion, praise, education
- Focus on current life issues: can examine past experiences on current life patterns
- Avoids prolonged silence, neutrality, confrontation
- Induced anxiety is avoided

Hellerstein et al 2004

Supportive Psychotherapy for BPD

- Plan ahead for next predictable event
- Clarify: “it seems that this is an example of the pattern that you find yourself in”
- Education: “this is common with people with BPD”
- “Striking when the iron is cold”
- Address emptiness by direct support

Hellerstein et al 2004
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Supportive Psychotherapy for BPD

the magic of “and”

The person may want to kill or cut herself, *and* may also have other choices

Suicide is a choice, *and* there may be other choices

Hellerstein et al 2004
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Assumptions about borderline patients and therapy (from Lenihan)

- Patients are doing the best they can
- Patient want to improve
- Patients need to do better, try harder and be more motivated to change
- Patients may not have caused all of their own problems but they have to solve them anyway

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Assumptions about borderline patients and therapy (cont)

- The lives of suicidal, borderline individuals are unbearable as they are currently being lived
- Patients must learn new behaviors in all relevant contexts
- Patients cannot fail in therapy
- Therapists treating borderline patients need support

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Dialectical Behavioral Therapy Skills		
Skill	Purpose	Techniques
<i>Mindfulness</i>	Relaxation and awareness	Observing, describing, and participating in the moment
<i>Emotion Regulation</i>	Reducing vulnerability to <i>emotion mind</i>	Labeling emotions, learning how they relate to actions, and taking care of yourself
<i>Distress Tolerance</i>	Enduring unavoidable distress	Distracting yourself with pleasurable activities and intense sensations
<i>Interpersonal Effectiveness</i>	Getting what you want from others without sacrificing self-respect	Prioritizing goals, being assertive, and negotiating effectively 35

Treatment planning is critical.

- A. Can allow the clinician to be proactive
- B. Involve the client

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Obtain a Careful History

Many people with a borderline diagnosis have been in the system for years without a careful history

- What has the person tried
- What has gotten in the way
- How has the person responded to problems
- Exceptions when things have gone well, or at least gone a bit better

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Consider that problem behavior is exacerbated by:

- Treatable medical illness
- Co-existing mental illness
- Sequel a of trauma
- Always consider substance abuse

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Be clear about the therapy contract

- A. What does the client want
- What are the client's treatment goals
 - What would "doing better" or "doing worse" mean
 - What commitment is the client willing/able to make

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Be clear about the therapy contract (cont)

- B. What do you want?
- What are you able to deliver
 - What can you not tolerate
 - Behavior
 - Risk

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Core Strategies for Therapy

- Validation
- Problem solving
- Skills training

Marsha Lenihan

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The importance of hope

- Building motivation
- Getting through the “bad times”

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Psychological Interventions

- Skill training
- Problem solving
- Affect-regulation strategies
- Learning affect tolerance

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Techniques of DBT that can be used in non DBT treatment

- Diary Cards
- Agenda Setting With Focus on Treatment Targets
- Intersession Contact for “in Vivo” Coaching
- Psychoeducation
- Behavioral Analysis Techniques”
- Coping Skill Development
- Clear and Precise Safety Plans

⁴⁶
Barbara Stanley

Techniques of DBT that can be used in non DBT treatment

- Diary cards
 - Track urges
 - Track problematic behavior
- Agenda setting
 - Explicit focus on treatment targets
 - Avoid continual “putting out fires:”

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Techniques of DBT that can be used in non DBT treatment

- Intersession contact for “in vivo” coaching
 - Not to say “I’m having a bad day”
 - Explicit: how do I fight the urges that I am having
- Psychoeducation about borderline personality disorder
 - Discuss issues of heightened emotional sensitivity
 - Disorder of self-regulation

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Techniques of DBT that can be used in non DBT treatment

- **Use of behavioral analysis techniques to understand pathways**
 - Start with the problem behavior—
 - Very detailed analysis of “what happened”
- **Coping skill development**
 - Distress tolerance
 - Interpersonal effectiveness
 - Emotion regulation
 - Cognitive control or mindfulness

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Techniques of DBT that can be used in non DBT treatment

- **Clear and precise safety plans**
 - NOT contracting for safety
 - Game plan for what to do when suicidal or having other urges
 - Developed in collaboration with client

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Risk

- **There is no way to treat clients with borderline personality disorder without taking risks**
- **Need to balance short term Vs long term risks**
 - Significant lifetime risk of suicide.
 - Responding to each suicidal event may make it more difficult for people to stabilize their lives.

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“Suicide” as shorthand for Dysregulated Affect

“I am suicidal” communicates negative emotions and confusion of what to do about them

- Being overwhelmed
- “I can’t stand it any more”
- “I need to die”

Communication style makes it hard for friends to give support, or person to receive support

Heap and Silk in Emergency Psychiatry ch 24 2008

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Contingent Suicide

- **“If you don’t...I’ll kill myself”**
- **VA sample followed 7 years**
 - Contingent threateners made NO attempts
 - 10% of depressed with no threats committed suicide
- **Contingent threateners more likely to be**
 - Antisocial, often with legal problems
 - Drug abusing
 - Homeless
- **But expressed threats made them hard to manage**

Lambert et al J Ment Health Admin 1997; 24 350-8
Report by Greist, 2008 Psych Update Conf

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Balancing risks

- **Discussed carefully with the client**
- **The client’s family**
- **Other members of the treatment team and support system**

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Cutting and other Self-Injurious Behavior

- The need to hurt oneself is different from the desire to kill oneself
- Cutting is a way to cope, to reduce anxiety
- Cutting is both a solution to a problem, and a problem
- A person can become suicidal when the cutting does not work

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Cutting:

I cut when I cant stand the pain anymore
....sometimes I get such an overwhelming wave of emotional pain that I feel like my soul will surely shatter completely.....I can feel the pressure building up till I have to do something. Suicide has proven a failure for me, so I resort to cutting, cutting gives me immediate release.... and the pain will subside for a while, giving me enough of a break to pull my Sh*T together temporarily.

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How to be helpful

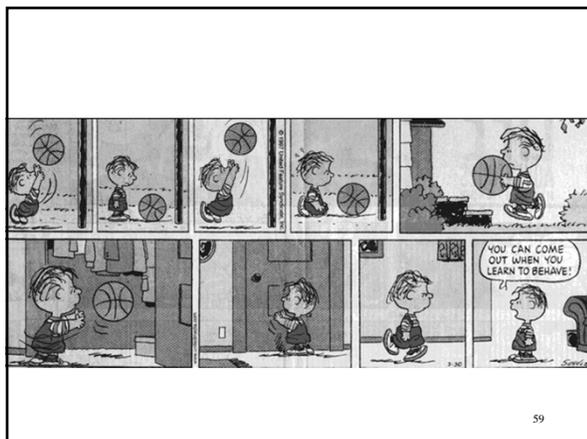
- LISTEN
- Do not over react or minimize
- Be careful about rescuing

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When you are stuck, enlarge the field.

- A. Involve other people in the client's support system.
- B. Involve other parts of the treatment system.
- C. Involve supports and consultants for yourself.

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Crisis Intervention is Critical

Crisis Vs ongoing life chaos

- Is this a crisis?
- Whom is this a crisis for?
- What is the crisis?

Do not get overwhelmed by the client's sense of crisis.

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The clinician does not have to "fix it"

- Being willing to "be there", to listen and to share the pain may be enough
- It may also be all that you can realistically do

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"Rub his belly, Emiel! Rub his belly!"

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Crisis (cont.)

Suicide is a real risk

- Need to feel pain Vs need to be dead
- Suicidal people do not want to be dead, they just do not want their life to continue as it is
 - Loss of hope
 - Impulsivity and poor object constancy
 - Substance use increases suicide risk
- Suicide involves someone beside patient

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Crisis (cont.)

Be careful about premature problem solving-especially

- Can interfere with relationship
- Can cause client to feel problems are being trivialized
- Can reinforce client's sense of powerlessness
- Often client just wants to be heard

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Crisis (cont.)

Plan for crisis Before the crisis

- Involve the client
- What works, what does not
- What can be tried that is different
- Who else can be involved

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WRAP: Wellness Recovery Action Plan

- Developing a wellness toolbox
- Daily maintenance plan
- Triggers
- Early warning signs
- When things are breaking down
- Crisis planning
- Post crisis plan

Mary Ellen Copeland

Role of the hospital

- Clear goals for use of hospital
- Use of crisis homes and other alternatives
- Use of hospital "contracts"

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Talking to people with personality disorders

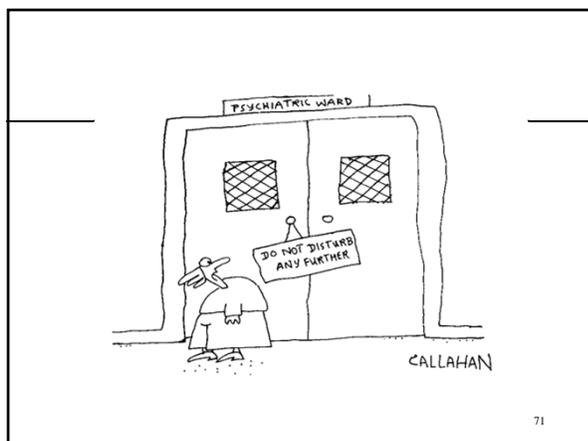
1. Enhance and maintain self esteem. Theirs not yours!!
2. LISTEN and respond with empathy. Remember you have two ears and one mouth -- so listen twice as much as you speak.
3. Ask for their suggestions to resolve problems and difficulties.. Use theirs whenever possible.
4. Conflict is inevitable - when at an impasse, when the temperature begins to rise, first ask yourself 'in what way is this person right?'

⁶⁹
John Santopietro and SR Thorward, from community psych listserve Jan 2011

Decreasing "hot" violence

- Be "on the client's side"
- Stress where you honestly agree
- Help where you can
- Avoid personalizing disagreements

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