Treating Persons with Borderline Personality Disorder

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Disclosures

• I have no financial involvement to disclose
• I will discuss some off-label use of drugs but no off-colored ones

Learning Outcomes

• Describe the putative neurophysiologic contributors of borderline personality disorder.
• Describe the psychosocial contributors of borderline personality disorder.
• Apply the biopsychologic contributors of borderline personality disorder in arriving at effective outcome-focused treatment.
Agenda

- What does borderline personality disorder (BPD) look like?
- What are causal factors for BPD?
- How can we treat BPD?

Ben’s Journey

- Both parents alcoholic
- Parents divorced when he was 4 years old
- Lived with his mother and 2 year old sister
- Sexually abused at 13 years old by adult neighbor for 10 days without his mother noticing he was missing
Ben’s Journey

• Angry and quiet boy
• Did poorly in school, stopped going when he was 13 years old

• Ran away from home when he was 14 years old, took his sister with him to protect her

• Convicted of grand larceny and served 14 months in prison at age 18 yrs
Ben’s Journey

• Many relationships with longest lasting 3 years
• Longest he kept a job was 2 ½ yrs
• Homeless off and on for years

Ben’s Journey

• History of prescription drug abuse and marijuana use

Ben’s Journey

• Currently on disability for HIV and Hepatitis
• Visiting ED’s, clinics 2/7 days/week
What Does BPD Look Like?

- DSM-5 Criteria for personality disorder:
  - Enduring pattern of inner experience and behavior that markedly differs from cultural expectations
    - Cognition
    - Affectivity
    - Interpersonal functioning
    - Impulse control
  - Pattern is inflexible and pervasive
  - Pattern contributes to significant distress

(Source: APA, 2013)

DSM-5 Criteria for BPD

- Pattern of instability in variety of contexts:
  - Frantic efforts to avoid real or imagined abandonment
  - Unstable and intense interpersonal relationships
  - Identity disturbance
  - Impulsivity
  - Recurrent suicidal or self-harm behavior

(Source: APA, 2013)

DSM-5 Criteria for BPD

- Affective instability with marked reactivity of mood
- Chronic feelings of emptiness
- Inappropriate, intense anger or difficulty controlling anger
- Transient, stress-related paranoid ideation or severe dissociation

(Source: APA, 2013)
What Do We See in Ben?

And Others?

• BPD affects 1-2% of the general population
• Up to 10% of psychiatric outpatients
• And 15-25% of psychiatric inpatients
• Characterized by severe psychosocial impairment
• High mortality rate due to suicide

(Source: Lieb, Zanarini, Schmahl, Linehan, Bohus, 2009)

More Epidemiology

• More common in women than men
• Community-based sample of children & adolescents 11% at 9-19 years old
• High co-morbidity
  – 41-83% major depressive disorder
  – 10-20% bipolar disorders
  – 64-66% substance use
  – 46-56% PTSD
  – 29-53% eating disorders
Stigma of BPD

Stigma

- BPD clients are “the patients psychiatrists dislike.”
- Described by MH providers as time-wasters, frequent flyers, manipulative, attention-seeking, and difficult
- MH providers who treat those with BDP bear a similar stigma and burden


What Causes BPD?

Source: Lieb, et al., 2004

- Genetic factors
- Adverse childhood experiences
- Emotional dysregulation
- Impulsivity
- Dysfunctional behaviors, e.g., self-injury, suicide, Psychosocial conflicts and deficits
Psychosocial Evidence

- Adverse events during childhood
  - Ongoing experiences of neglect and abuse
  - Childhood sexual abuse reported in 40-71% of inpatients with BPD
  - Difficulty attaining stable attachment
  - Pattern of overt and covert invalidation
  - Learned self-invalidation
  - Rejection sensitivity

(Sources: Lieb, et al., 2004; Linehan, 2014; Strauss, Mestel, Kirchmann, 2011, Chesin, et al., 2015)

Emotional Dysregulation

- BPD criterion behaviors function to regulate emotions or are a consequence of failed emotional regulation
- Biological vulnerability with intense sensitivity
- Interferes with problem solving
- Reinforces inability to control own emotions

Dysfunctional Behaviors

- Intolerant of frustration and distress
- Unable to self-soothe
- Oscillation between emotional inhibition and extreme emotional communication
- Shame as primary emotion and reactive response is self-injurious behaviors and interpersonal conflicts
Genetic Evidence

- Genetic data minimal: 35% and 7% of monozygotic and dizygotic twins
- Trait analysis shows consistency in: emotional dysregulation, unstable cognitive functioning, unstable sense of self, unstable interpersonal relationships
- Is this due to environment or genetics?

Epigenetics

- Gene expression linked with symptoms and behaviors
  - Emotional dysregulation related to serotonin transporter changes
  - Impulsivity and novelty seeking related to changes in the dopaminergic system, esp. in reward center

Neurological Evidence

- Little specific research, better to consider target symptoms or behaviors
- Those with NSSI have lower levels of endogenous opioids. Serotonergic and dopaminergic dysfunctions not correlated with NSSI (Stanley, et al., 2010)
- Marked reduction of N-acetylaspartate in dorsolateral prefrontal cortex (van Elst, et al. 2001)
Target Symptoms

- Impulsivity: Disruption in circuit of ventral striatum to thalamus to ventromedial PFC to anterior cingulate
- Chronic suicidality: Orbitofrontal cortex, amygdala
- Chronic depression: Orbitofrontal cortex, dorsolateral PFC, amygdala
- Behavioral inhibition: Medial PFC

Target Symptoms

- Behavioral activation: PFC, cingulate, caudate
- Social attachment: Nucleus accumbens
- Behavioral persistence: Orbitomedial cortex, nucleus accumbens

What Happened to Ben?
How Can We Treat BPD?

- Psychotherapy
- Pharmacotherapy
- Combined psychotherapy and pharmacotherapy

Psychotherapy Evidence

- Dialectical Behavior Therapy
- Mentalization-Based Therapy
- Cognitive Behavior Therapy
- Transference-focused Therapy
- Interpersonal Therapy
- Systems Training for Emotional Predictability and Problem Solving (STEPPS)

(Source: Stoffers, et al, 2013)

Dialectical Behavior Therapy

- Based on skill development and motivation
  - Mindfulness
  - Interpersonal effectiveness
  - Emotional regulation
  - Distress tolerance
- Individual therapy for reinforcement and in vivo practice
- Consultation to client and to therapist

(Source: Linehan, 2014)
Mentalization-Based Therapy

- Mentalizing: capacity to understand own and other’s behavior in terms of internal mental states (feelings, thoughts, values)
- Enhancing mentalization improves symptoms and interpersonal functioning
- Psychodynamic approach based on attachment theory and cognitive psychology

(Sources: Bateman & Fonagy, 2004; Fonagy, Bateman, Bateman, 2011)

Cognitive Behavior Therapy

- Focuses on maladaptive schemas or pervasive patterns of thinking, feeling, and behaving
- Recognition of self-perpetuating processes
- Changing schemas through cognitive and experiential work

Pharmacotherapy Evidence

- Mood stabilization targeting emotional dysregulation and impulsivity
  - Lithium associated with decrease in irritability and suicidal thinking
  - Carbamazepine decreased frequency & severity of behavioral dyscontrol
  - Valproate marked reduction in agitation, irritability, and impulsive aggression
  - Lamotrigine marked improvement in impulsivity & mood lability

(Sources: Bellino, et al., 2008; Stahl, 2013)
• Depression and anxiety
  – Serotonin reuptake inhibitors: fluoxetine, fluvoxamine, citalopram
  – Serotonin-norepinephrine reuptake inhibitors: venlafaxine and duloxetine
  – Alpha & beta blockers
  – Benzodiazepines contraindicated
  – Serotonin-dopamine antagonists: lurasidone, quetiapine, olanzapine-fluoxetine combination, asenapine

Focus in Prescribing
• Goal is simplified regimen, maximizing before giving up on a medication
• Supporting effective brain functioning to make use of psychotherapy
• Requires different assessment process
  – Listening in relation to neurophysiology
  – Using medications to support and improve neurophysiology
  – Separating operant behavior from biologic

Challenges in Prescribing
• Expecting the medication to all the work
• Resisting medications
• Hypersensitivity to adverse effects
• Non collaborative changing of medications
• Family member’s responses
• Substance use
Augmentation Strategies

- One change at a time
- Start where the client wants the greatest change
- Maximize dosage before adding another drug
- Adding based on neurophysiology and complimentary mechanisms of action

Complimenting Strategies

- Serotonin reuptake inhibitors
- Serotonin agonists and antagonists
- Getting more out of each medication
  - Drowsiness as side effect to aid sleep
  - Mood stabilization, inhibiting impulsivity, decreasing anxiety

Commitment Strategies

- Stages of change
- Process of change
- Collaboration in medication choices, dosing, and expectations
- Contingencies and rewards
How Can We Help Ben?

Questions? Comments?

References

References

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