Working Effectively with Patients with Borderline Personality Disorder

Brian Palmer, MD, MPH
Psychiatry and Psychology
Conflict of Interest Disclosure

Honorarium  None
Stock or Patents  None
Consulting  None
Publishing/Royalties  None
Organization  None
Government  None

- Off-label use of medication will be described for classes of medications
Outline

• Overview of BPD
  • Emphasis on interpersonal nature of symptoms

• Course and Outcome
  • Emphasis on comorbidity

• Treatment approaches
  • Psychosocial principles
    • Emphasis on clarifying experience and reducing reactivity
  • Biological principles: Do no harm
Borderline means…

“Trouble. I am probably going to be unable to satisfy them, especially if they are not under the care of a psychiatrist.”

“Heartsink! Truly, as much as I try to have compassion and understanding for these patients, the convoluted and circuitous thinking leaves my brain hurting.”
Borderline means…

“Manipulation by the patient and then anger towards me when they perceive I won’t do what they want.”

“… go out of their way to make things difficult for me. When they present a problem they want to have you help solve, there are always conditions that make any solution untenable.”
Personality Disorders

• Cluster A
  • Paranoid, schizoid, schizotypal

• Cluster B
  • Antisocial, borderline, histrionic, narcissistic

• Cluster C
  • Avoidant, dependent, obsessive-compulsive
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
BPD’s Interpersonal Coherence

**Connected**
idealizing, dependent, rejection-sensitive

**Threatened**
devaluating, self-injurious, angry, anxious, help-seeking

**Alone**
dissociated, paranoid, impulsive, help-rejecting

**Desperate**
suicidal, anhedonic

**Interpersonal Stress**

Support by the other
Withdrawal by the other

Holding (hospital, jail, rescuer)

Gunderson 2014
Basic Epidemiology

• Prevalence
  • Roughly ~20% of clinical samples
  • 1.2 - 5.9% of the community samples

• Gender
  • Approximately ~75% female in clinical samples
  • More equal M:F ratio in community samples
Heritability / Familiality

- Across two twin studies, one family study
  - 55% heritability for BPD
  - Single latent factor accounts for the co-occurrence of interpersonal, emotional, behavioral and cognitive components

Gunderson, Arch Gen Psychiatry, 2011;
Distel, Biological Psychiatry, 2009
Presented Facial Expressions to BPD and Healthy Control group while undergoing fMRI scan.

Region of Interest: Amygdala, associated with automatic processing of potentially threatening stimuli.
Amygdala Hyperreactivity
(Ekman Faces)
Response to Facial Expressions

With intranasal oxytocin administration, marked reduction in amygdala activation in borderline patients.

Bertsch, Am J Psych, 2013
Make the Diagnosis

• 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 impact the accuracy of BPD assessments
  Morey 2010
BPD’s Longitudinal Course

*From the Collaborative Longitudinal Study of Pers Disorders (i.e., Gunderson, Archives 2011)

**From the McLean Study of Adult Development (i.e., Zanarini, Am J Psych, 2003)
Outcomes

• After 10 years one third had full-time work.
  Gunderson 2011

• BPD has a markedly negative effect on MDD (“treatment resistance”) until BPD remits, but MDD has only modest effects on BPD’s course.
  Yoshimatsu and Palmer 2014

• BPD is most common reason for persistence of depression.
  Skodol 2011
Empirically Validated Treatments

- Dialectical Behavioral Therapy (DBT)
  - Linehan et al., 1993, 2006

- Mentalization Based Treatment (MBT)

- 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 & Prob. Solving (STEPPS)
  - Blum et al., 2008

- General Psychiatric Management (GPM)
  - McMain et al., 2009 (after Gunderson & Links)
A Spectrum of Approaches

Cognitive Behavioral

DBT

STEPPS

Psychodynamic

MBT

SFT

TFP

GPM
Effective Clinical Management of BPD

April 19, 2017

Los Angeles, CA
John Gunderson, MD
Brian Palmer, MD

ce.mayo.edu
Common Features of Effective TX

- Structured (groups and individual work)
- Coherent and stable, not reactive
- Crisis planning
- Supervision for managing countertransference
- Therapists are active
- Monitoring progress and goals
- Making narrative sense of internal experience
Reactive Treatment: Perilous

- Persons with BPD often seek treatment REACTIVELY

- Example: Migraine Headaches
  - more medication overuse headaches
  - more unscheduled (acute) office visits
  - lower overall treatment response

Rothrock, Headache, 2007
Goal

• Help the patient figure out what they’re experiencing and what they want.
  • 1. Lower emotion and clarify experience by validating. “Get” the patient.
  • 2. THEN, consider what to do.
  • 3. Avoid “BUT” and use “AND”
  • 4. Motivational interviewing style. Name the dilemma but don’t provide the solution (let the patient do that).
Patient Video
Problem: Circular Thinking

• Make sense of nonsense
  • “Circular thinking” and “demanding” means high emotion with low cognition.
  • First, lower emotion by validating
  • Then find a “both-and” way to think together. When something doesn’t make sense, say so!

“I’d guess this whole thing is scary. You certainly didn’t ask for this struggle. Help me understand the problem you want help with?”
Problem: Demands

• Your job is to practice medicine within the standards of care. Observe your limits.
  • Let patients know directly what you will and won’t do as part of your practice.
  • It’s good to address the process.

“I never prescribe benzodiazepines and opioids and stimulants together; you can choose which one you think is most helpful and necessary.” (“Surely you don’t want me to do something that I think is unsafe?”)
Problem: You feel guilty

• It’s okay to have your own (negative) feelings.
  • Most of us can’t stand feeling negative emotions toward people we’re supposed to help. It’s okay. Better to acknowledge!
  • Pulling away from a patient in distress can be harmful. Acknowledge, get support, try to stay engaged.
  • Sometimes telling the patient of your frustration can help (they have it too!).

"Is this as frustrating for you as it is for me?!"
Problem: Splits

• The “good” side of the split is harder – and most important – to see. If a patient with BPD is devaluing of a colleague or other staff:
  • Avoiding opining on your colleague’s behavior
  • Redirect the patient to your colleague – frame it as an opportunity.

“I think Dr. Leep Hunderfund would want to hear about your concern, and I think it would be good for you to try to tell her. Up for it?”
Meds: Key Principles

1) Collaborate to determine goals and set expectations
   Reduce headache frequency (measured by…)
   Reduce headache intensity (measured by…)
   Reduce days of work missed, etc

2) Measure the effectiveness of the intervention

3) Use a methodical approach to medication trials.
   Careful on adding without subtracting

4) Hold reasonable limits
## At a Glance – One Missing Class?

<table>
<thead>
<tr>
<th></th>
<th>Antipsychotics</th>
<th>Antidepressants</th>
<th>Mood Stabilizers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anger</td>
<td>++</td>
<td>+</td>
<td>+++</td>
</tr>
<tr>
<td>Depression</td>
<td>0</td>
<td>0</td>
<td>+</td>
</tr>
<tr>
<td>Anxiety</td>
<td>0</td>
<td>+</td>
<td>++</td>
</tr>
<tr>
<td>Impulsivity</td>
<td>+</td>
<td>0</td>
<td>+++</td>
</tr>
<tr>
<td>Cognitive/Perceptual</td>
<td>++</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Functioning</td>
<td>+</td>
<td>0</td>
<td>++</td>
</tr>
</tbody>
</table>

*Adapted from Ingenhoven 2010*
Thank you!

palmer.brian@mayo.edu