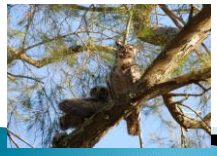
BORDERLINE PERSONALITY UPDATE

Pamela Marcus, RN APRN/PMH-BC
MarcusRN@verizon.net



CONFLICT OF INTEREST

- Ms. Marcus has no conflicts of interest.
- There are no discussions of off-label medications in this presentation

OBJECTIVES

- Define the behaviors that comprise the criteria for the diagnosis for Borderline Personality Disorder (Case Study)
- Discuss new research into biological etiology of BPD
- Identify three nursing interventions that reduce the symptoms of anxiety and impulsive behavior that are commonly exhibited by an individual with BPD

DSM -5 Diagnostic Criteria

DSM 5 CRITERIA FOR BPD

- A pervasive pattern of instability of interpersonal relationships
- Disturbed self-image
- Instable affects
- Marked impulsivity beginning by early adulthood and is present in a variety of contexts

DSM 5 CRITERIA FOR BPD

- Frantic efforts to avoid real or imagined abandonment
- Unstable and intense interpersonal relationships – alternating between extremes of idealization and devaluation
- Identity disturbance; unstable self-image or sense of self

DSM 5 CRITERIA FOR BPD

- Impulsivity in at least two areas that are potentially self-damaging
  - Spending
  - Sex
  - Substance abuse
  - Reckless driving
  - Binge eating

DSM 5 CRITERIA FOR BPD

- Recurrent suicidal behavior, thoughts, or threats, or self-harming behavior
- Affective instability due to a marked reactivity of mood
  - Intense episodic dysphoria
  - Irritability
  - Anxiety
  - Usually lasting a few hours; not more than a few days

DSM 5 CRITERIA FOR BPD

- Chronic feelings of emptiness
- Inappropriate intense anger or difficulty controlling anger
- Transient, stress-related paranoid ideation
- Severe dissociative symptoms

CASE STUDY

- Jessie is a 25 year old women who was admitted to the inpatient unit due to a suicide attempt after her boy friend broke up with her. She had pushed him after he refused to take her to a popular singer's concert. He left her house after she pushed him and told him that the relationship was over. The relationship has been rocky during it's duration, over the last 3 months.

CASE STUDY

- Jessie responded to her boyfriend leaving by cutting her wrists and calling 911. This is her second admission in 6 months. Each admission had to do with a break up with a significant relationship.
- Jessie has a history of sexual abuse when she was ages 5-10 by her mother's brother.

Theories of Etiology

NEW RESEARCH: BIOLOGICAL CAUSES OF BPD

- Low 5-HT (Serotonin 5-hydroxytryptamine) synthesis capacity in corticostriatal pathways may contribute to impulsive behaviors in individuals with BPD

NEW RESEARCH: BIOLOGICAL CAUSES OF BPD

- Neurotransmission of serotonin and impulsive behavior
- Female and male subjects with BPD who have high impulsivity scores have serotonergic disturbances

NEW RESEARCH: BIOLOGICAL CAUSES OF BPD

- Brain imaging research shows no clear specific neurocircuitry model for BPD
- There is a decrease in volume, especially gray matter in the anterior cingulate gyrus; particularly in men
- Women may have a reduction in gray matter in the medial temporal lobe
- The above changes in volume may be due to comorbidity of PTSD and MDD

NEW RESEARCH: BIOLOGICAL CAUSES OF BPD

- Continue research on structural imaging in adolescents with BPD
- Study of the response of prefrontal modulation during emotional provocation
- Understand molecular abnormalities to define discrete symptoms in BPD
- Study the physiological components that contribute to interpersonal disruptions, such as misinterpretation of facial emotional expression

ABANDONMENT ANXIETY

OBJECT RELATIONS: OTTO KERNBERG

- Definition: "stability and depth of the patient's relations with significant others as manifested by warmth, dedication, concern, and tactfulness

OBJECT RELATIONS: OTTO KERNBERG

- Qualitative aspects:
  - Empathy
  - Understanding
  - Ability to maintain a relationship when it has conflict or frustration

OBJECT RELATIONS: MARGARET MAHLER

- Developed a theory of separation and individuation
- This theory discusses the child's intrapsychic self-representation and separate representation of the mother

OBJECT RELATIONS: MARGARET MAHLER

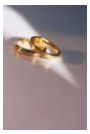
- The child's tasks during the first three years of life : to develop a separate identity
- Development of object constancy occurs around twenty five months of age

OBJECT RELATIONS: MARGARET MAHLER

- Object constancy is the ability to maintain a relationship even during times of frustration and changes in the relationship
- Self soothing is used to cope when the child's needs are not met by the care taker

OBJECT RELATIONS: MARGARET MAHLER

- Self soothing represents the care taker to the child
- As an adult, object constancy is more abstract but represents someone/or something that is meaningful to the individual and is calming



OBJECT RELATIONS: MARGARET MAHLER

- A person with Borderline Personality Disorder has not been able to achieve object constancy and can not utilize any self soothing mechanisms to calm his/her fears, emotions take over the behavior

OBJECT RELATIONS: JAMES MASTERSON

- Identified four defenses that block the patient's growth based on Mahler's stages
  - Projection
  - Clinging
  - Denial
  - Avoidance

OBJECT RELATIONS: JAMES MASTERSON

- Six constituent feelings related to feelings of abandonment
  - Depression
  - Anger and rage
  - Fear
  - Guilt
  - Passivity and helplessness
  - Emptiness and void

OBJECT RELATIONS: JAMES MASTERSON

Individuals with BPD react to abandonment anxiety with impulsive behavior such as suicidal ideation, self-harm, alcohol and/or substance use, binge eating, and shop lifting

PATIENT'S VIEW OF SELF

- Feels different: "No one understands me."
- Frequently suicidal
- Self-harm occurs to decrease feelings of numbing and/or intense affect, such as rage

PATIENT'S VIEW OF SELF

- The feelings often experienced by the individuals with BPD are:
  - Fear
  - Anger
  - Depression

FAMILY DYNAMICS

- Linehan's work involved assessing the family communication patterns that demonstrate invalidating environment
- Family members respond to each other in an emotional reactive and unpredictable manner

ASSOCIATED FEATURES

- Individuals with BPD often have a history of physical and sexual abuse, neglect, conflict, early parental loss, separation or neglect.
- The individual with BPD may experience transient psychotic-like symptoms, such as hearing their name called during times of stress

ASSOCIATED FEATURES

- Individuals with BPD unconsciously undermine their achievement of goals by severely regressing or becoming impulsive

ASSOCIATED FEATURES

- People with BPD have difficulty with interpersonal relationships.
- They may relate to positively to pets or inanimate objects
- Individuals with BPD have difficulties relating to others, and blames others for the interpersonal conflicts

COMORBIDITY

- Commonly comorbid with mood disorders, substance related disorders, eating disorders, particularly bulimia, PTSD, panic disorder and ADHD
- Can have comorbidity with antisocial, avoidant, histrionic, narcissistic, and schizotypal personality disorders

COMPLICATIONS

- There is a high rate of death by suicide, 8-10%, which is 50 times higher than the general population
- There is a higher rate of suicide if the individual is young (in his/her 20's), and has co-occurring mood disorders or substance use disorders

COMPLICATIONS

- Death by suicide is more common after the age of 30 when there have been failed attempts of obtaining treatment for BPD
- High rate of impulsivity and a history of childhood abuse increases the possibility of suicide attempts in individuals with BPD
- Poor social relationships increase the possibility of suicide

COMPLICATIONS

- Difficulty functioning at work or in an academic setting, particularly if there in an unstructured environment
- High rate of job loss or interrupted education

COMPLICATIONS

- High rate of interpersonal relationship problems at work, school and in friendships or marital relationships
- High rate of divorce

ASSESSMENT AND INTERVENTIONS

ASSESSMENT

- Is the patient demanding, hostile?
- Does the patient have a history of aggressive actions?
- Is there poor impulse control?
- Does the patient have thoughts of harming self or others?

ASSESSMENT

- Is the patient suspicious of others?
- Does the patient express fear or high anxiety?
- Are there feelings of helplessness?
- Does the individual demonstrate critical behavior towards self and/or others?
- Does the individual have a low self-esteem?

ASSESSMENT

- Is the individual concerned about how others will evaluate him/her?
- Is the individual vindictive?
- Does the person demonstrate low frustration tolerance?
- Does the person demonstrate mood lability?

ASSESSMENT

- Does the patient demonstrate cognitive distortions by misinterpretation of stimuli and communication of others?
- Does the person's identification of problem areas involve blaming others?
- Is the person impulsive?
- Does the person learn from his/her mistakes?

ASSESSMENT

- What is the presence of risk-taking and impulsive behaviors?
- Are there mood disturbances and emotional reactivity?
- Is there suicidal ideation and intent?
- Is there a risk of violence towards others and/or property?

ASSESSMENT : SELF-HARM

- How did the patient identify his/her feelings prior to self-harm?
- Did the cutting (or other acts) relieve tension?
- Is feeling pain or seeing blood an important part of this activity?

ASSESSMENT

- Are there the use of substances?
- Does the patient have the ability to care for self and others, such as children and pets?
- What are the financial concerns and resources?
- How does the patient identify his/her psychosocial stressors?
- Who constitutes the patient's support system, family and friends?

EFFECTIVE THERAPEUTIC PRACTICES

- Psychotherapy:
  - Weekly meetings
  - One to two group sessions weekly
  - Dialectical behavior therapy consists of cognitive behavioral therapy that takes place in I hour individual therapy and 2.5 hours of group skills training per week for 6-12 months.
    - Therapists must be trained in the specifics of DBT (Linehan, et al,)

EFFECTIVE THERAPEUTIC PRACTICES

- Gabbard suggests the following approach:
- Interpretation
- Confrontation
- Clarification
- Encouragement to elaborate
- Empathic validation
- Advice and praise
- Affirmation

INTERVENTIONS THAT WORK: SUICIDAL IDEATION

- Assess using the CASE Approach (Shea)
- Consider this a serious psychiatric emergency
- Determine impulse control
- Personalize the need for safety monitoring
- Assist the individual to recognize the precipitant of the ideation during this episode
- Determine other options for solving the current crisis
- Use the Safety Planning Intervention (Stanley, B and Brown, GK. (2012)

SELF-HARM DUE TO ALEXYTHYMIA

- Teach the person about the concept of alexythymia
- Assist the person to recognize intensely emotional periods by using a journal
- Teach the person exercises to reassociate
- Wrapping is self soothing (Dresser, 1999)

PSYCHOPARMACOLOGICAL INTERVENTIONS

- SSRI antidepressants treat the symptoms of affective dysregulation and impulse dyscontrol
- SSRI decrease depressed mood, anger, and impulsive aggression, including self-harm
- Lithium carbonate and anticonvulsant mood stabilizers can be used to treat the symptoms of affective dysregulation and behavioral dyscontrol
- Neuroleptics can reduce the acute symptoms of psychosis, anger and hostility

PSYCHOPARMACOLOGICAL INTERVENTIONS

- Anxiolytic agents can be used to treat anxiety.
- NOTE: The use of alprazolam was associated with greater suicidal drive and behavioral dyscontrol
- The use of anxiolytic agents can increase the potential for abuse and tolerance

NURSE'S INTERACTIONS CAN ENHANCE PATIENT FUNCTIONING

BASICS FOR EFFECTIVE TREATMENT

- Be consistent
- Be honest !!!!!
- Admit mistakes
- Learn the patient's language
- Ask the patient what he/she is thinking and feeling (these are often different)

BASICS FOR EFFECTIVE TREATMENT

- Constantly clarify what was heard (and what meaning was drawn from it)
- Teach appropriate self nurturance
- Keep consequences clear and consistent and up front

BASICS FOR EFFECTIVE TREATMENT

- Set limits when you are not angry
- Teach to recognize, label and share feelings verbally
- Assist the patient to connect his/her feelings with behavior
- Use language and actions that emphasize accountability
- Encourage realistic goal setting and self acknowledgment

BASICS FOR EFFECTIVE TREATMENT

- Discuss ways to use humor
- Use analogy to known things
- Develop strategies for managing boundaries
- Assist in recognizing personal "warning signs"

BASICS FOR EFFECTIVE TREATMENT

- Create "bridges" for effective coping during crisis
- Address: "If I get better, you will go away"

IDENTIFY YOUR OWN FEELINGS

- Reflect on your own feelings
- Determine how your interaction effects the patient's therapeutic goals
- Maintain professional boundaries
- Utilize clinical supervision and/or peer supervision
- Recognize when you have needs that you need to meet prior to working with complex patients

Image by Lee Marcus, used with permission

BIBLIOGRAPHY

- American Psychiatric Association (2013) *Diagnostic and Statistical Manual of Mental Disorders,* Fifth Edition. Washington, DC: American Psychiatric Association Press.
- American Psychiatric Association. Practice guideline for the treatment of patients with borderline personality disorder. Retrieved September 15, 2012 from http:// www.psych.org/psych-pract/treatg/pg/borderline-revisebo
- Akin, E., Cetin, M., & Kose, S. (2017). An update on borderline personality disorder: Life in the fast lane. *Journal of Mood Disorders, 7*(1), 65-72. doi:http://dx.doi.org.ezproxy.pgcc.edu/10.5455/jmood.20170308073312

BIBLIOGRAPHY

- Bateman, A. W., Gunderson, J., & Mulder, R. (2015). Treatment of personality disorder. *The Lancet, 385*(9969), 735-743. doi:http://dx.doi.org.ezproxy.pgcc.edu/10.1016/S0140-6736(14)61394-5
- Bukh, J. D., Bock, C., & Kessing, L. V. (2014). Association between genetic polymorphisms in the serotonergic system and comorbid personality disorders among patients with first-episode depression. *Journal of Personality Disorders, 28*(3), 365-78. doi:http://dx.doi.org.ezproxy.pgcc.edu/101521pedi201327123
- DeShong, H. L., & Kurtz, J. E. (2013). Four factors of impulsivity differentiate antisocial and borderline personality disorders. *Journal of Personality Disorders, 27*(2), 144-56. doi:http://dx.doi.org.ezproxy.pgcc.edu/101521pedi2013272144

BIBLIOGRAPHY

- Distel, MA, Middledorp, CM, Truill, TJ, Derom, CA, Willernsen, G, Boomsma, DI. (2011) Life events and borderline personality features: the influence of gene-environment interaction and gene-environment correlation. *Psychol Med* Apr 41(4): 849-860
- Drapeau, M, Perry, JC, Körner, A. (2012) Interpersonal patterns in borderline personality disorder. *Journal of Personality Disorders* 26 (4): 583-592.
- Dresser, J. (1999) Wrapping: A technique for interrupting self-mutilation. *Journal of the American Psychiatric Nurses Association.* (April): 67-70.
- Linehan, MM; Tutek, DA; Heard, HL; Armstrong, HE. ((1999) Dialectical behaviour therapy for patients with borderline personality disorder and drug-dependence. *American Journal of Addictions* (8): 279-292 {A}

BIBLIOGRAPHY

- Mack, M., & Nesbitt, H. M. (2016). Staff attitudes towards people with borderline personality disorder. *Mental Health Practice (2014+), 19*(8), 31. doi:http://dx.doi.org.ezproxy.pgcc.edu/10.7748/mhp.19.8.31.s20
- New, A. S., M.D., Perez-Rodriguez, M., & Ripoll, L. H., M.D. (2012). Neuroimaging and borderline personality disorder. *Psychiatric Annals, 42*(2), 65-71. doi:http://dx.doi.org.ezproxy.pgcc.edu/10.3928/00485713-20120124-07
- O'Neill, A, Frodi, T. (2012) Brain structure and function in borderline personality disorder. *Brain Structure and Function.* 217 (4):767-782.

BIBLIOGRAPHY

- Renaud, S, Corbalan, F, Beaulieu, S. (2012) Differential diagnosis of bipolar affective disorder type II and borderline personality disorder: analysis of the affective dimension. *Comprehensive Psychiatry* 53 (7): 952-961.
- Ritter, S., & Platt, L. M. (2016). What's new in treating inpatients with personality disorders?: Dialectical behavior therapy and old-fashioned, good communication. *Journal of Psychosocial Nursing & Mental Health Services, 54*(1), 38-45. doi:http://dx.doi.org.ezproxy.pgcc.edu/10.3928/02793695-20151216-03
- Shea, SC (2009) Suicide Assessment Part 1: Uncovering suicidal intent a sophisticated art. *Psychiatric Times* (26): 1-6.
- Shea, SD (2009) Suicide Assessment Part 2: Uncovering suicidal intent using the Chronological Assessment of Suicide Events (CASE Approach). *Psychiatric Times* (26): 1-26.

BIBLIOGRAPHY

- Stanley, B and Brown, GK. (2012) Safety planning intervention: A brief intervention to mitigate suicide risk. *Cognitive and Behavioral Practice* 19(2012): 256-264. www.sciencedirect.com . retrieved July 30, 2017. Available at http://www.suicidesafetyplan.com.
- Yao, J., Xu, Y., Qin, Y., Liu, J., Shen, Y., Wang, W., & Chen, W. (2015). Relationship between personality disorder functioning styles and the emotional states in bipolar I and II disorders. *PLoS One, 10*(1) doi:http://dx.doi.org.ezproxy.pgcc.edu/10.1371/journal.pone.0117353
- Zimmerman, M. (2016). Improving the recognition of borderline personality disorder in a bipolar world. *Journal of Personality Disorders, 30*(3), 320-335. doi:http://dx.doi.org.ezproxy.pgcc.edu/101521pedi201529195

BIBLIOGRAPHY

- Zimmerman, M., Martinez, J., Young, D., Chelminski, I., Morgan, T. A., & Dalrymple, K. (2014). Comorbid bipolar disorder and borderline personality disorder and history of suicide attempts. *Journal of Personality Disorders, 28*(3), 358-64. doi:http://dx.doi.org.ezproxy.pgcc.edu/101521pedi201327122