BORDERLINE PERSONALITY DISORDER

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GENERAL OVERVIEW

Personality disorders are concerned with personality traits

Personality traits are general ways of thinking, feeling, and behaving

Only diagnosed with a personality disorder when these traits are inflexible, maladaptive, and cause significant impairment or subjective distress

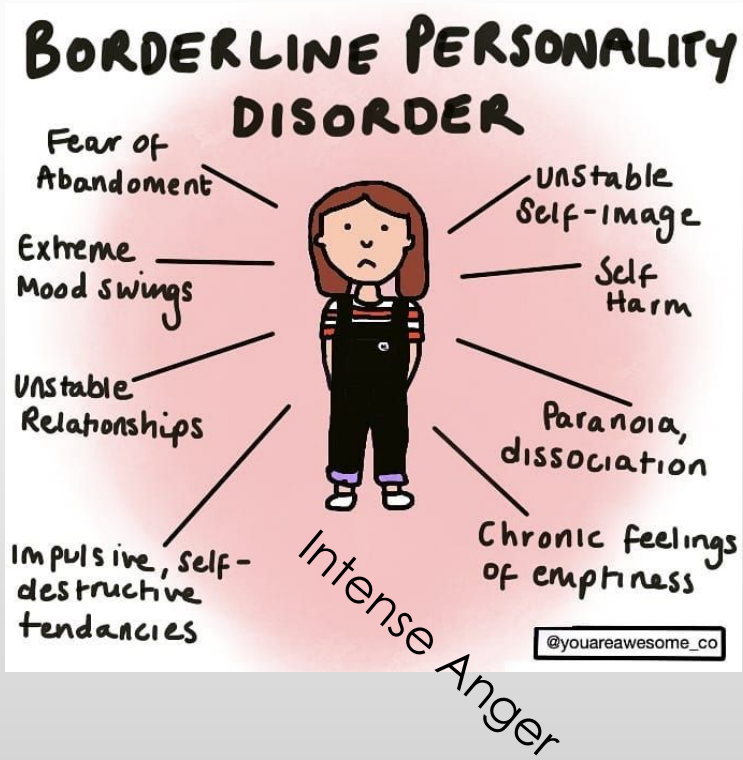
Cluster B

EMOTIONAL REGULATION

"The processes by which we influence which emotions we have, when we have them, and how we experience and express them" (Gross, 1988)

WHAT IS BORDERLINE PERSONALITY DISORDER?

- A pervasive pattern of instability of interpersonal relationships, self-image, and moods
- Noticeable impulsivity beginning by early adulthood and present in a variety of contexts
- Indicated by five (or more) of the following 9 symptoms:



DIAGNOSTIC CRITERIA FOR BPD

1. Frantic efforts to avoid real or imagined abandonment

DIAGNOSTIC CRITERIA FOR BPD

2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation

DIAGNOSTIC CRITERIA FOR BPD

3. Identity disturbance: noticeable and persistently unstable self-image or sense of self

DIAGNOSTIC CRITERIA FOR BPD

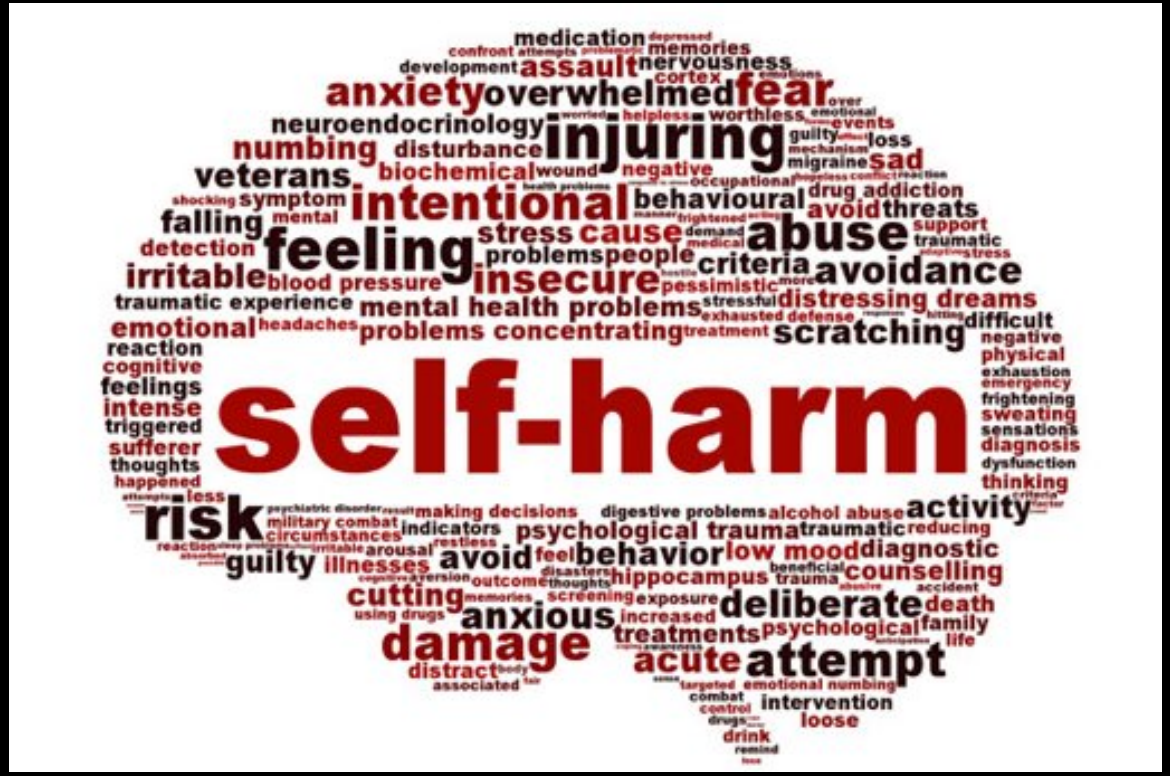
4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, binge eating)

impulsive (adj.)

motivated by emotion rather than thought; spontaneous actions based on desires, whims or inclinations

DIAGNOSTIC CRITERIA FOR BPD

5. Recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour



DIAGNOSTIC CRITERIA FOR BPD

6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)

DIAGNOSTIC CRITERIA FOR BPD

7. Chronic feelings of emptiness

DIAGNOSTIC CRITERIA FOR BPD

8. Inappropriate, intense anger or difficulty controlling anger (e.g. frequent displays of temper, constant anger, recurrent physical fights)

DIAGNOSTIC CRITERIA FOR BPD

9. Transient, stress-related paranoid ideation or severe dissociative symptoms

- The number of symptoms experienced vary from person to person (some experience a few, while others experience many)
- Symptoms may fluctuate
- Symptoms can be triggered by seemingly ordinary events

BRIEF HISTORY

The term *borderline* was first used in 1938 (Adolph Stern) to describe patients who were on the "border" of *psychosis* and *neurosis*

Psychosis => delusions, hallucinations, significant impairment in judgement and cognitive processes (considered to be untreatable/ difficult to treat)

Neurosis => mild mental illness due to stress (e.g. anxiety, depression, hypochondria, etc.) still in touch with reality (considered to be treatable)

DEVELOPMENT AND COURSE (DSM-V)

- Symptoms typically appear during adolescence (teenage years) or early adulthood
- Early symptoms can occur during childhood
- Considerable variability in the course of BPD: The most common pattern is one of chronic instability in early adulthood, with episodes of serious emotion dysregulation and impulsivity, requiring high levels of use of health/ mental health resources

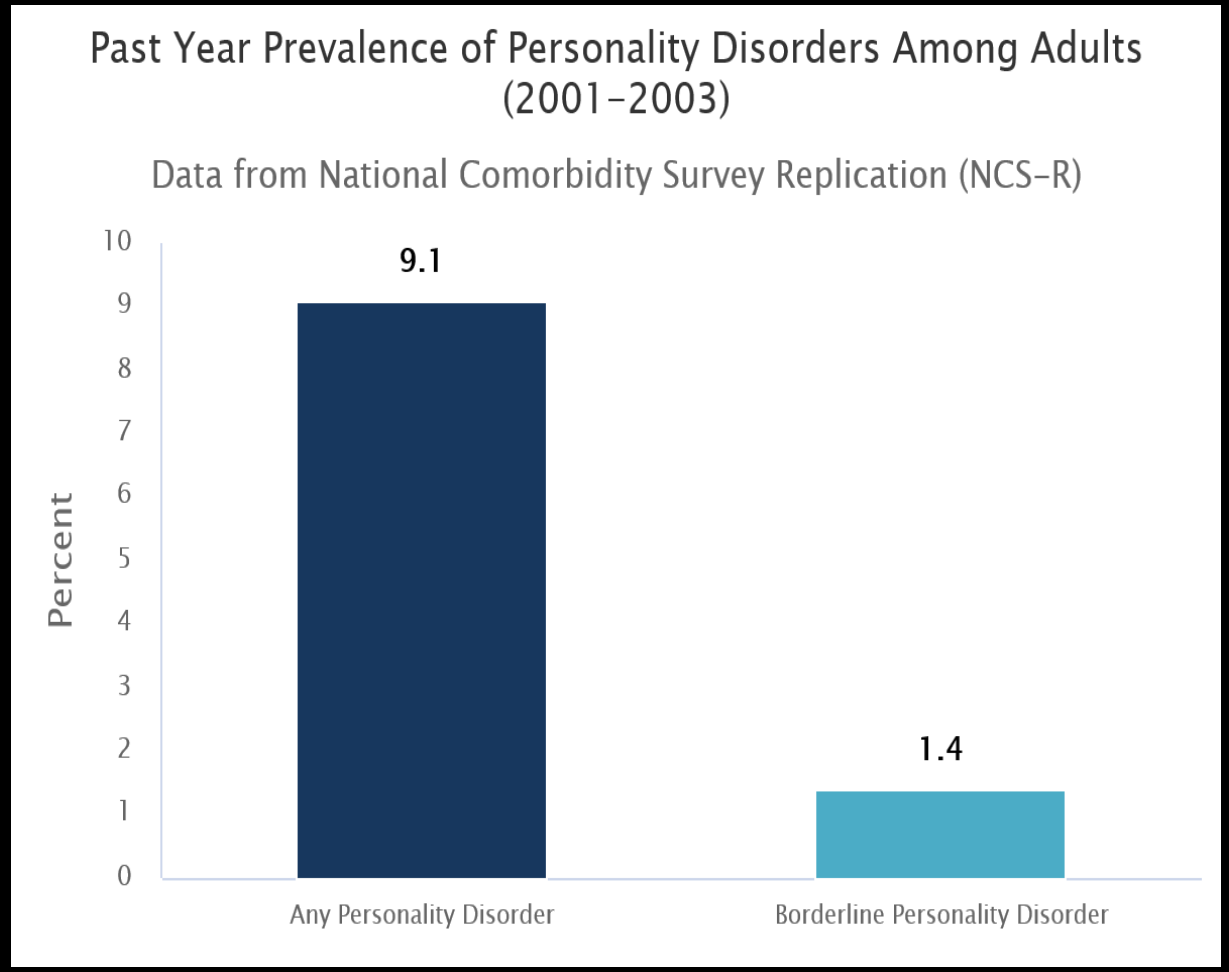
DEVELOPMENT AND COURSE (DSM-V)

- Risk of suicide greatest in the young-adult years, risk gradually reduces with age
- The majority of those with BPD are able to attain greater stability with work and in relationships during their 30s and 40s.
- Although the tendency toward intense emotions, impulsivity, and intensity in relationships is often lifelong – can show improvement with therapeutic intervention
- Up to half of outpatients no longer meet the full criteria for BPD after 10 years of therapeutic intervention

PREVALENCE (DSM-V)

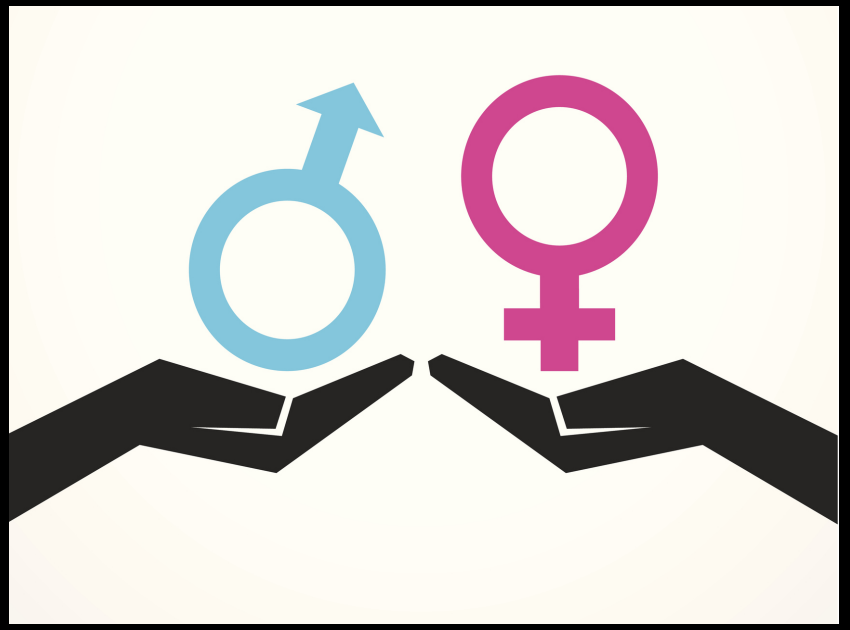
- 1% - 6% of general population
- About 6% in primary care settings, 10% in outpatient settings, and 20% in psychiatric inpatient settings
- 8% - 10% of those with BPD commit suicide
- The prevalence of BPD may decrease in older age groups

National Institute of Mental Health



GENDER AND CULTURAL-RELATED DIFFERENCES (DSM-V)

- Initially thought to be more common in women, however later studies found that BPD affects both sexes equally
- According to the DSM V, BPD is diagnosed predominantly in females (75%) - Why could this be?
- Men with BPD were often misdiagnosed with depression or PTSD
- Differences have been found in the symptoms experienced by males versus females (Sansone & Sansone, 2011)
- No race/ cultural differences have been identified



GENDER DIFFERENCES IN BORDERLINE PERSONALITY DISORDER: RESULTS FROM A MULTINATIONAL, CLINICAL TRIAL SAMPLE (SILBERSCHMIDT, LEE, ZANARINI, SCHULZ, 2014)

Included men and women between the ages of 18-65

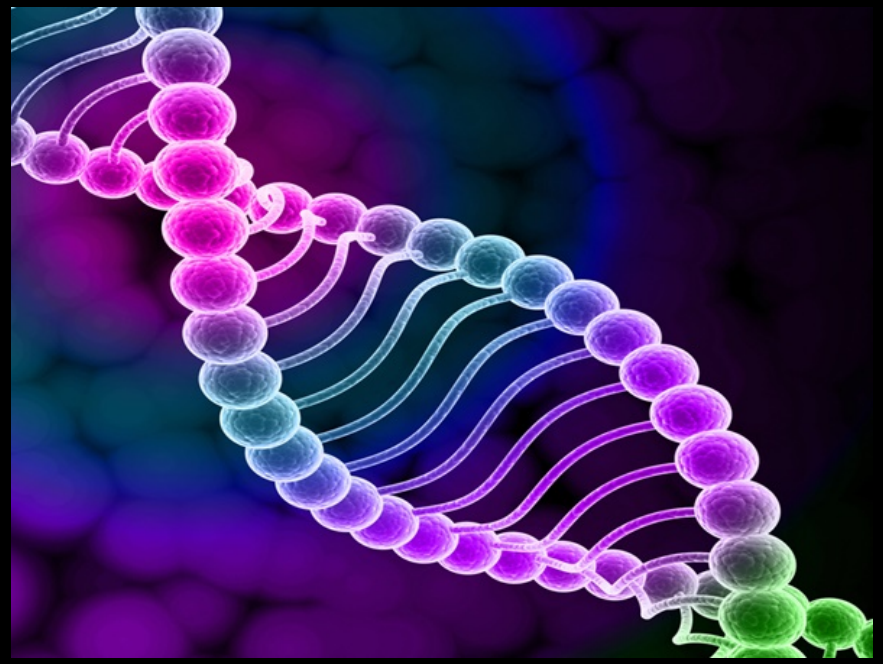
Used diagnostic and self-report measures

Found that women with BPD have greater hostility and relationship disruption compared to men with BPD

Consistent with general population differences: women show greater overall symptomatology than men

Contrary to general population differences, no gender differences found in aggression, suicidality, substance abuse, panic disorder, or obsessive-compulsive disorder among those with BPD

RISK FACTORS (DSM-V)



- Not fully understood but appear to be the result of a combination of factors

Genetics

- No specific gene has been identified
- Twin studies suggest strong hereditary links
- BPD is five times more common among people who have a first-degree relative with the disorder
- Increased familial risk for substance use disorders, antisocial personality disorder, and depressive or bipolar disorders

RISK FACTORS (DSM-V)

Neurological

- The brain works differently in people with BPD, suggesting neurological basis for some of the symptoms
- The portions of the brain that control emotions and decision-making/ judgement may not communicate well with each other due to defects in various neurotransmitter systems
- History of head trauma, epilepsy, encephalitis, other brain abnormalities
- Severe hyperactivity, distractibility, and learning disabilities

RISK FACTORS (DSM-V)

Environmental Factors

- Childhood history of physical and sexual abuse, neglect, hostile conflict, and/or parental loss
- Exposure to unstable, invalidating relationships, and hostile conflicts
- Other traumatic life events (e.g. abandonment, witnessing abuse, etc.)

COMORBIDITY (DSM-V)

Those with BPD often experience and are diagnosed with other conditions/ disorders (95.7%). Common co-occurring conditions/ disorders are:

- Mood disorder (e.g. depression, bipolar) – 76%
- Anxiety disorder - 75.7%
- Alcohol and substance abuse – 48.6%
- Neurodevelopmental disorder – 31.1%
- Attention Deficit Hyperactivity Disorder (ADHD) – 30.9%
- Eating disorders
- Post-traumatic stress disorder
- Other personality disorders

*statistics from Skoglund et al., 2019

INTELLECTUAL DISABILITIES (ID) (DSM-V)

Intellectual disability is characterized by deficits in general mental abilities, such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning, and learning from experience.

INTELLECTUAL DISABILITIES (ID) (DSM-V)

The deficits result in impairments of **adaptive functioning**, such that the individual fails to meet standards of personal independence and social responsibility in one or more aspects of daily life

ADAPTIVE FUNCTIONING

Adaptive functioning involves adaptive reasoning in three domains: **conceptual**, social, and practical.

The *conceptual (academic) domain* involves competence in memory, language, reading, writing, math reasoning, acquisition of practical knowledge, problem solving, and judgment in novel situations, among others.

ADAPTIVE FUNCTIONING

Adaptive functioning involves adaptive reasoning in three domains: conceptual, **social**, and practical.

The *social domain* involves awareness of others' thoughts, feelings, and experiences; empathy; interpersonal communication skills; friendship abilities; and social judgment, among others.

ADAPTIVE FUNCTIONING

Adaptive functioning involves adaptive reasoning in three domains: conceptual, social, and **practical**.

The *practical domain* involves learning and self-management across life settings, including personal care, job responsibilities, money management, recreation, self-management of behavior, and school and work task organization, among others.

ASSOCIATED FEATURES SUPPORTING DIAGNOSIS (DSM-V)

- Difficulties with motivation
- Lack of communication skills = disruptive and aggressive behaviors.
- Difficulties with assessment of risk
- Gullibility is often a feature, involving naivete in social situations and a tendency for being easily led by others. Gullibility and lack of awareness of risk may result in exploitation by others and possible victimization, fraud, unintentional criminal involvement, false confessions, and risk for physical and sexual abuse.

BORDERLINE PERSONALITY DISORDER AND INTELLECTUAL DISABILITY DISORDER

WHAT DOES THIS MEAN?

FACTORS THAT AFFECT ADAPTIVE FUNCTIONING

Intellectual capacity, education, motivation, socialization, personality features, vocational opportunity, cultural experience, and coexisting general medical conditions or mental disorders influence adaptive functioning.

This means that adaptive functioning can increase or decrease based on these factors

TREATMENTS AND THERAPIES

- Psychotherapy is the main form of treatment
- Can be provided 1:1 with the therapist and patient or in a group setting
- Therapist-led group sessions can help teach people with BPD how to interact with others and express themselves effectively
- Dialectical Behaviour Therapy (DBT) was created specifically for the treatment of BPD and is currently most widely used

TREATMENTS AND THERAPIES

In addition to DBT, there are other types of psychotherapy that have also been found to be effective:

- CBT: Cognitive Behaviour Therapy
- STEPPS: System Training for Emotional Predictability and Problem Solving
- MBT: Mentalization-Based Therapy
- Transference-Focused Psychotherapy
- Schema Therapy
- Interpersonal/ Group Therapy

TREATMENTS AND THERAPIES

- Medication can be used to treat symptoms (e.g. anxiety, mood swings, etc.)
- Hospitalization
  (involuntary is danger to self/ others, serious physical impairment)
- Psycho-education: understanding BPD, treatments available, how to manage symptoms, etc.

HOW TO SUPPORT

- Avoid power struggles
- Identify strengths/ interests
- Use a strengths-based approach
- Adapt the living environment
- Regular check-ins (talk time)
- Use of visual supports
- Self-monitoring

DAILY LIVING ACTIVITIES

- Healthy Routines
- Sleep
- Diet
- Exercise
- Hygiene/ Grooming
- Engagement in activities: indoor/ outdoor
- Engagement in activities: individual and group
- Coping and relaxation

9 STRATEGIES FOR SUPPORTING SOMEONE WITH BPD

(CRISIS AND TRAUMA RESOURCE INSTITUTE)

- Learn about BPD
- Show Confidence and Respect
- Be Trustworthy
- Manage Conflict with Attachment
- Take Suicide Seriously
- Be Self-Aware
- Have Fun Together!

BURNOUT

Exhaustion due to the nature of this profession

Warning signs: Anxiety, avoiding people, depression, exhaustion, feeling you're losing control of your life, irritability, lack of energy, losing interest in the things you like to do, neglecting your needs and health

Physical symptoms: Body aches and pains, fatigue, frequent headaches, increased or decreased appetite that may cause changes in weight, insomnia, weakened immune system leading to frequent infections

Other: Becoming angry and argumentative, impatience, inability to concentrate

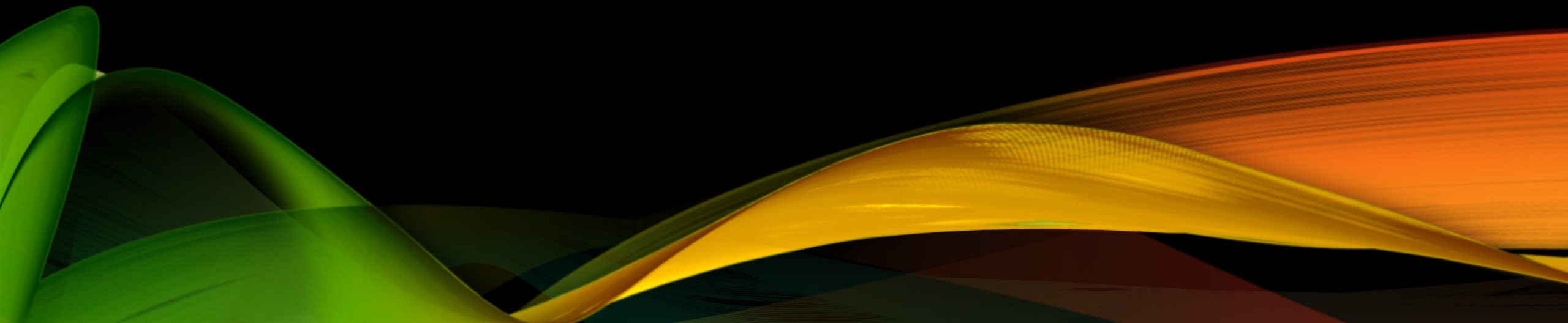
BURNOUT

What are the consequences of this?

What can you do to prevent this from happening?

HTTPS://WWW.YOUTUBE.COM/WATCH?V=NMFUDKJ1AQ0&T=169S

THANK YOU!



REFERENCES

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders: DSM-5. Arlington, VA: American Psychiatric Association.

Churchill, A. (n.d.). 9 strategies for supporting people with borderline personality disorder. *Crisis and Trauma Resource Institute. Retrieved from* https://ca.ctrinstitute.com/blog/9-strategies-supporting-bpd/

Gross, J. J. (1998). The emerging field of emotion regulation: An integrative review. *Review of General Psychology, 2*(3), 271-299. doi:10.1037//1089-2680.2.3.271]

National Alliance of Mental Illness. (2015). Borderline Personality Disorder. Retrieved July 17, 2019 from https://www.nami.org/Learn-More/Mental-Health-Conditions/Borderline-Personality-Disorder

National Institute of Mental Health. (2017). Personality Disorders. Retrieved July 20, 2019 from https://www.nimh.nih.gov/health/statistics/personality-disorders.shtml

REFERENCES

Sansone, R. A., & Sansone, L. A. (2011). Gender patterns in borderline personality disorder. *Innovations in Clinical Neuroscience, 8*(5), 16–20.

Şenol, S. (2019, May 16). Borderline personality disorder. Retrieved July 19, 2019, from https://www.britannica.com/science/borderline-personality-disorder

Silberschmidt, A, Lee, S., Zanarini, M., Schulz, S.C. (2014). Gender differences in borderline personality disorder: Results from a multinational clinical trial sample. *Journal of Personality Disorders, 28*(175), 1-11.

Skoglund, C., Tiger, A., Rück, C., Petrovic, P., Asherson, P., Hellner, C., Mataix-Cols, D., & Kuja-Halkola, R. (2019). Familial risk and heritability of diagnosed borderline personality disorder: a register study of the Swedish population. *Mol Psychiatry.* Retrieved from https://doi.org/10.1038/s41380-019-0442-0.