Concept and Management of Borderline Personality

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Introduction

Stern 1938 referred category of psychopathology as 'Borderline' to describe patients who fit in neither psychotic nor neurotic syndrome

"These are clinically challenging and extremely difficult to handle effectively by any psychotherapeutic model"

Why borderline?

- Bordering on psychosis, neurosis, organicity spectrum
- Studies suggesting 11 to 36% having non specific organic pathology
- Earlier concept of pseudoneurotic pathology
- DSM I concept of emotionally unstable personality

Background and evolution of concept

- Psychodynamic concept- clearly describe metapsychological features of the disorder as well as it's developmental precursors
- Neurobehavioural model
- Categorical concept
- Cognitive processing model

Kernberg Model 1975

- Focus not on syndrome but characteristic mental functioning
- Certain constitutional phenomena combined with environmental deficiencies = Borderline
- Excess aggressive drive, lack of anxiety tolerance, primitive defenses
- Failure to acquire emotional object constancy

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BPD construct

- Identity diffusion
- Primitive defenses (Projective identification, splitting)
- Intact reality testing

Associated with affective and behavioural dysregulation

Masterson and Rinsley Model 1975

- Mother's withdrawal of libidinal supplies at developmental stage when child attempts to separate from mother in search of identity

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Abandonment depression

arrest of ego development

- Ego diffusion is central concept with use of primitive reflex of splitting

Adler 1985

- Derived from concept of self psychology and Piaget's theory of cognitive development
- Deficient environment and absence of good enough mothering during separation-individuation phase lead to unstable self identity
- Failure to achieve evocative memory
- Central concept- unstable self identity

Primary emptiness

To Summarise

Psychodynamic theories emphasized on interpersonal and developmental dimension concerned with ego identity formation

1. Borderline pathology is manifestation of early developmental deficits that result in unresolved self conflict
2. Need to substitute emptiness with new more stable images of positive self-object

Neurobehavioural model 1985

- Minimal brain dysfunction
- Hyperactivity, short attention span, distractibility, mood oscillations, high impulsivity

Construct

- Confused cognition
- Affect dysregulation
- Defective/inadequate impulse control

Cognitive Model - Bowlby1980

- Three types of memory systems important for relationship

1. Semantic memory- generalizations about relationship
2. Episodic memory – events experienced between self and others
3. Procedural memory- patterns of behaviour representing learned feelings, expectations regarding interactions

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- Mismatch between learned expectations and perceptions about new relationship.
- Impaired capacity to decode feelings
- Emotions expressed through temperamental disposition

Construct:

- Unstable attachment
- Affective dysregulation
- Unstable temperament

Borderline construct

Categorical Psychodynamic- (Kernberg, Adler)

- Identity diffusion
- Primitive defenses
- Intact reality

contd

Gunderson 1975 (clinical and dynamic criteria)

- Low achievement
- Manipulative self injurious behaviour
- Intense mood changes
- Transient loss of reality
- High socialization
- Disturbed close relationship

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Categorical Model (APA 1980-DSM III, Spitzer & Williams 1980)

- Identity disturbances
- Unstable intense relationships
- Impulsivity that is potentially self damaging
- Inappropriate intense anger
- Physically self damaging acts
- Affective instability
- Chronic feelings of emptiness, boredom
- Problems tolerating being alone

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Dimesions of object relations and social cognition

Dimensional Model - Westen et al 1990

- Complexity of representation of others
- Affect tone
- Capacity of emotional investment
- Understanding of social causality

contd

Dimensional Model Milon 1987

- Affective responses
- Type of cognitive functioning
- Pattern of interpersonal behaviour
- Self concept

Contd

Clarkin et al 1991

Cluster analysis

- Identity cluster
- Affect cluster
- Impulse cluster

Sub typing Borderline

Grinker 1966, outlined typology of borderline based on functions of ego

1. Lowest functioning group- Borderline psychosis
2. Core borderline group
3. Adaptive affectless- 'as if' group
4. Depressive group that bordered on neurosis

Factor analytic studies

Core features

- Diffuse self concept
- Affective instability
- Unstable interpersonal relationships

Additional Features

- Separation protestation
- Brief stress related Psychosis

Examining construct validity

- Most studies used DSM III/IV crieria
- CFA support one and three factor model

1. Disturbed relatedness
2. Affective dysregulation
3. Behavioural dysregulation

- The ability to distinguish BPD from BD according to deviations in temperament and character dimensions support uniqueness of construct

Challenges

- Dimensional Model better accepted, but possibly require merging of categorical and dimensional model
- The boundaries of the disorder still need to be defined
- Klein,1977; Akiskal 1985,1992 advocated elimination of BPD-Affective component overriding so should be included and treated as Bipolar spectrum disorder

Current understanding

- Most studies suggest good reliability and descriptive validity
- Temporal stability of diagnosis, moderate predictive validity
- Boundaries not clearly defined and often show overlap with Bipolar disorder
- But CFA studies support notion that the construct is valid and not simply a variant of bipolar disorder

Management

Outcome Predictors (Stone 1993)

Positive predictors

- Higher IQ
- Distractibility
- Shorter hospitalizations
- Talent, attractivness
- Absence of parental divorce

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Negative Predictors

- Substance abuse
- Affective instability
- Antisocial traits
- Dysphoria
- Narcissistic traits
- Chronic feelings of emptiness, boredom

Diificulties and challenges

- Complexity of condition
- Comorbid axis I disorders
- Few criteria themselves are symptom like eg. suicidal acts. Ego syntonicity of which add to problem
- Totality of personality needs to be taken in account
- Therapy needs to be tailored to dimensional understanding

Pharmacotherapy

- Adjunct to control target symptoms
- Cognitive-perceptual symptoms- Low dose atypical APD
- Affect dysregulation
- Behaviour dysregulation} SSRI

Mood stabilizers ↓

- Role of CBZ, Fluanxol, Naltrexone

Psychological Intervention

1. Psychoanalytically oriented therapies
2. Cognitive Behavioural therapies
3. Supportive psychotherapy

Psychoanalytically oriented

Focus: strive to promote psychic integration through careful examination of polarized attitudes

Primarily combine dynamic and supportive principles

Classic analysis not possible

Techniques

- Gunderson's stepwise progression model
- Gabbard's combination of supportive and dynamic techniques
- Kernberg's Transference focussed psychotherapy (TFP)
- Kohut- 'Borderline states are not analyzable' suggest supportive dynamic approach based on self psychology

Cognitive behavioural therapies

Focus:

- Observable behaviour, psychic schemas
- Decrease dichotomous thinking, develop better control of emotions, impulses, strengthen self identity

DBT ↓

Dialectic behaviour Therapy (Linehan)

Core strategies:

- Validation and reassurance
- Problem solving

Modes of treatment:

- Individual therapy
- Group skills training
- Telephone contact
- Therapist consultation

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Stages of therapy

- Pre assessment stage- focus on assessment, commitment, orientation to therapy
- Stage1- focus on suicidal behaviour, therapy interfering behaviour, behaviour interfering with quality of life, problem solving skills
- Stage2- deals with post traumatic stress related problems
- Stage3- focus on self esteem & individual treatment goals

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Skills training

- Core mindfulness skills
- Interpersonal effectiveness skills
- Emotion modulation skills
- Distress tolerance skills

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strategies to manage difficult situations in therapy

- Contingency management
- Cognitive therapy
- Exposure based therapy
- Pharmacotherapy

Supportive psychotherapy

Applebaum & Levy manual

Techniques:

- Sympathetic listening
- Education and encouragement
- Limit setting
- Exhortations
- Reassurance and validation
- Advice

Kernberg and Linehan Hierarchy of management

1. Make sure suicidality is explored and treaed adequately
2. Deal promptly with threats of discontinuing treatment
3. Inquire and treat severe non suicidal symptoms
4. Be alert of dishonesty or withholding information
5. Once above taken care of deal with less disruptive symptoms

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6. Focus on personality traits causing significant trouble
7. Focus on personality traits more troublesome to patient than to others
8. Focus on long range occupational, educational and interpersonal goals

Thank you...