Mental Health Association of Northern Kentucky

A LEADER IN PROVIDING ADVOCACY, EDUCATION, AND SERVICES THAT PROMOTE MENTAL WELLNESS

EDUCATION AND SCREENING OUTREACH PARTNER FOR THE NATIONAL INSTITUTE OF MENTAL HEALTH AND NATIONAL MENTAL HEALTH ASSOCIATION

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BORDERLINE PERSONALITY DISORDER

Diagnostic Criteria

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1) frantic efforts to avoid real or imagined abandonment. Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.

2) a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation

3) identity disturbance: markedly and persistently unstable self-image or sense of self

4) impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.

5) recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior

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)

7) chronic feelings of emptiness

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

9) transient, stress-related paranoid ideation or severe dissociative symptoms

Associated Features

Depressed Mood

Addiction

Dramatic / Erratic / Antisocial Personality

Differential Diagnosis

Mood Disorders ; Histrionic Personality Disorder ; Schizotypal Personality Disorder ; Paranoid Personality Disorder ; Narcissistic Personality Disorder ; Antisocial Personality Disorder ; Dependent Personality Disorder ; Personality Change ; Due to a General Medical Condition; symptoms that may develop in association with chronic substance use; Identity Problem.

Medical Treatment

Basic Principles

Persons with borderline personality disorder have marked difficulty in differentiating reality from fantasy, so that a minor health problem may be perceived as a life-threatening event. These patients ward off their catastrophic fear of being damaged by imperfect caretakers by imagining them as "all-good." If any problems occur, patients switch abruptly to an "all-bad" image of medical personnel; the omnipotent rescuer becomes the persecutory invader. The physician should be careful to avoid encouraging the patient to idealize the physician and should not be drawn into the patient's denigration of other physicians. The physician's tolerance of the patient's episodic angry outbursts demonstrates to the patient that the physician cannot be destroyed by the patient's strong negative feelings and that the physician will not retaliate by leaving the patient to a self-fulfilling prophecy of abandonment. The use of medications in the treatment of borderline patients is a complex topic. There is no drug of choice, and many clinicians feel that avoidance of medications is important in both the short- and long-run.

Hospitalization

The hospital frequently enters into the treatment of the borderline patient. The emergency room can be a source of empathic reassurance, crisis intervention, and education in spite of its drawbacks for psychiatric assessment and treatment. There is no working alliance in the emergency room, so support is paramount and interpretation should be absent. Medications should be directed at specific symptoms or at crisis management. Disposition is difficult, with power struggles often being part of the negotiations. Immediate return to the ongoing outpatient therapeutic system is important, as is referral for new psychotherapeutic treatment if the patient has no therapist. The clinician must be careful not to reinforce the splitting which may be present in a patient who is already being treated elsewhere but turns also to the emergency room. Short-term inpatient treatment should direct the patient toward responsible actions and assist in transition to definitive outpatient therapy. Acute hospitalization may allow for more accurate diagnosis and observation of the defensive organization of the patient. In addition, during the hospitalization period the patient's environmental and interpersonal supportive systems can be evaluated in preparation for the outpatient tasks to come. The issue of the hospital's potentiating the tremendous regressive potential in these patients must be addressed. There should be a dependable situation on the ward, not a dependent one Hospital units which provide long-term treatment for borderline patients should be highly specialized, and should not confuse the major psychodynamic issues involved with those more typical of frankly psychotic, severely depressed, or neurotic patients. A number of authors feel that the borderline patient with high regressive potential can best be treated in a long-term, intensive, highly structured inpatient environment. The characteristics of this environment and the treatment within it are much the same as those described in the section on Narcissistic Personality Disorder. The long-term treatment program should be seen as an environment in which the patient experiences development, and in which

staff (particularly the primary therapist) consistently accompany and empathize with the patient. Unless the treatment environment is highly structured and the staff are sensitive to the needs and deficits of the patient, transient psychosis may be encountered. Closeness with the patient should be developed gradually, to allow him or her to experience, and then contain and work with, feelings of panic. Goals include decreasing acting out, clearly identifying and working with inappropriate behaviors and feelings, accepting with the patient the magnitude of the therapeutic task, fostering more effective interpersonal relationships, and working with both real and transference relationships within the hospital.

Anti-psychotic Drugs

During brief reactive psychoses, low doses of anti-psychotic drugs may be useful, but they are usually not essential adjuncts to the treatment regimen, since such episodes are most often self-limiting and of short duration. It is, however, clear that low doses of high potency neuroleptics (e.g., haloperidol) may be helpful for disorganized thinking and some psychotic symptoms. Depression in some cases is amenable to neuroleptics. Neuroleptics are particularly recommended for the psychotic symptoms mentioned above, and for patients who show anger which must be controlled. Dosages should generally be low and the medication should never be given without adequate psychosocial intervention.

Antidepressant Drugs

Monoamine oxidase inhibitors have been used for patients with borderline personality disorder who are sensitive to rejection. These patients experience intensely unpleasant affects, particularly anxiety and depression, when they feel rejected. The use of other antidepressants may become necessary at certain times.

Anti-anxiety Drugs

Anti-anxiety agents may become necessary at certain times. The repeated use of medication for patients' frequent complaints of anxiety should be considered only with caution.

Psychosocial Treatment

Basic Principles

Like Narcissistic Personality Disorder, patients with Borderline Personality may be seen in a variety of settings. For the patient who comes to the clinician only during times of crisis, reality issues should rapidly be addressed in spite of the patient's frequent tendency to avoid problems. Availability of local mental health facilities helps the borderline patient with occasional crisis needs to function in the community. The rapid mood shifts in Borderline Personality patients make suicidal behavior common and dangerous. Suicide potential should be particularly carefully evaluated in the presence of poor reality-testing or incipient psychosis. Treatment of other symptoms and Axis I disorders which occasionally present in these patients should be as outlined elsewhere in this volume; however, the underlying personality disorder must not be ignored. These patients are fragile and prone to rapid disorganization or deterioration. Whatever approach the therapist takes in the treatment of the borderline patient, he needs to combine elements of both conflict resolution and social learning on a manner designed to minimize and limit regression. Finally, the treatment of borderline personalities should not be undertaken without support for the therapist such as readily available supervision or consultation, and a

cooperative hospital that serves as back up during periods of severe regression and heightened suicidal risk.

Individual Psychotherapy

Controversy exists about which of the 2 dominant psychological approaches is more effective in the treatment of borderline personality disorder. Long-term psychotherapy with some supportive modifications tries to develop trust early in treatment and progresses to deeper exploration with time. The other approach is long-term, more reality-oriented supportive psychotherapy that does not focus on unconscious fantasies and attempts instead to provide structure and prevent the deterioration or over-stimulation sometimes seen in more insight-oriented approaches. The setting of limits and the acknowledgment of the demands of reality are two important issues in psychotherapy. The patient's acting out can be dangerous for him/herself and others, and can make therapy impossible. Unless limitations on behavior are observed, the treatment should not proceed and the patient should be seen as insufficiently motivated. Transference and counter transference are particularly important aspects of psychotherapy for primitive patients such as those with Borderline or Narcissistic Personalities. The therapeutic alliance should form within the patient's real experiences with the therapist and with the treatment. The therapist must be able to tolerate repeated episodes of primitive rage, distrust, and fear. Uncovering is to be avoided in favor of bolstering of ego defenses, in order to eventually allow the patient to be less anxious about potential fragmentation and loss. The goals of therapy should be in terms of life gains toward independent functioning, and not complete restructuring of the personality. Successful treatment of the borderline disorders may lead the patient to resemble one with a Narcissistic Personality. Whatever approach the therapist takes in the treatment of the borderline patient, the elements of both conflict resolution and social learning must be combined in a manner designed to minimize and limit regression. In addition, the treatment of borderline personalities should be undertaken only with support for the therapist; such support should include readily available supervision or consultation and a cooperative hospital to serve as back up during periods of severe regression and heightened suicidal risk.

Group Therapy

Group treatment should be supportive rather than exploratory, especially in the outpatient setting. As noted in the section on the Narcissistic Personality Disorder, work in groups decreases potential discomfort related to intimacy, strong transference reactions, crises of authority, and the like.