Borderline personality disorder and deliberate self harm: GP talk, July 21

Dr. Nick Bendit

Centre for Psychotherapy

Personality Disorder

- Definition - *A personality disorder is a way of thinking, feeling and behaving that deviates from the expectations of the culture, causes distress or problems functioning, and lasts over time*

- *Q* – How does a personality disorder differ from a personality trait?

Self Disorder

Attempted definition – a confusion or lack of sameness in our inner world from which we experience and interact with the outer world.

- It's the "I" in the person undergoing the experience.
- It's the "I" separate from you.

- *Q* – Do you know who you are?

Self Disorder

Consequences

- Inconsistency - who the “I” is depends on the experience (externally validated, external locus of control). Seek attachment to someone/thing to assist them create a more stable inner environment
- Boundary confusion, ie overidentifying, over or under responsible.
- Difficulty initiating or completing (lack of stable drive and goals), unstable self worth

Borderline Personality Disorder

- Lack of stable inner environment manifests as
- - relationship difficulties
- - behaviour difficulties
- - emotional difficulties

Diagnostic Criteria

5/9 “am suicide”

1. A = abandonment sensitivity
2. **M = mood instability**
3. **S = chronic suicidality or self harm**
4. U = unstable or intense relationships
5. I = impulsivity (D&A, sex, food, spending, dangerous stuff – minimum of 2!)

Diagnostic criteria continued

6. C = controlling anger difficult
7. I = identity disturbance (“do you know who you are?”)
8. D = dissociation (strange unrealness of inside or outside, auditory hallucinations, unexplainable gaps in memory, multiple identities)
9. E = emptiness or pervasive boredom

Aetiology

- Sexual abuse x, violence x, DV x, ….
- Attachment trauma

- Q- Difference between Borderline PD and Complex PTSD?

Aetiology illustrated

- Emotional invalidation: child falls over and scrapes their knee
- Emotional display avoidance
- Compensatory behaviours (self harm, impulsivity, dissociation)
- breakthrough experiences (mood instability, unstable rels, suicide, anger, dissociation)
- Loss of (emotional) “self” (abandonment sensitivity, emptiness, identity loss)

Function of deliberate self harm

- Klonsky (2007) reviewed seven functions of self harm (usual medical explanation?)
- Greatest support for the function of affect regulation
- Replicated in lab experiments
- also evidence for self punishment
- Less evidence for anti-dissociation and coping with urge to suicide (not “attention”)

Suicide in BPD

- Around 10%
- Deliberate self harm in teens and early 20s
- Suicide in 30s (Paris, 2002)
- Deliberate self harm and suicide attempts infrequent or rare in 40s
- But, 18% death rate over 27 year study = reduced longevity

Problems with Assessment

- Different priorities (eg DSH, being alive)
- Lack of trust (parents, partners, previous treatment + **you/me**)
- Intense anger, devaluation when….
- Idealization when….

Problems with Comorbidity

- Depression (80% [Zanarini et al, 1998])
- Bipolar disorder (8%)
- Psychosis
- Drug and alcohol (15-60%)
- Eating disorders (40%)
- Anxiety disorders (85%, with PTSD 50%)
- Dissociative identity disorder, Pers Dis's

Can I have treatment for my Bipolar Doc?

Is it Bipolar?

- Depression and mood elevation are more persistent and last longer
- Mania - "a distinct period of abnormally and persistently elevated expansive, irritable mood and abnormally and persistently increased activity or energy lasting at least 1 week and present for most of the day, nearly every day"
- Mood symptoms less likely to be triggered by current events in Bipolar, can fluctuate multiple times in a day in Borderline personality disorder

Initial Assessment

(after “How can I help you”, the order below may be crucial!)

1. Empathic inquiry to current emotional situation with empathic feedback, not “persecutory” data collection)
2. Establish diagnosis
3. Assess DSH, drug use
4. Assess safety (acute vs chronic suicidality, past suicide attempts, hospital admissions)
5. Treatments past and present: Thx, meds

Initial Assessment continued

5. Psychological Resources: capacity to manage crises
6. Social resources: family, friends
7. Professional resources: psychotherapist or counsellor, psychiatrist, mental health team
8. How to contact re crises, follow-up
9. What stage (of change) are they? What do they want?

In the Octagon – Defence mechanisms

- Splitting – inability to validate both sides, tendency to idealise or devalue
- Projection – unrecognised unwanted feelings are attributed to others.
- Projective identification – unrecognised unwanted feelings are attributed to others with behaviour to engender these feelings in the other

In the Octagon – Emotional grappling

- Transference – patient directs feelings towards the therapist belonging to a significant other in their life

- Counter transference – the therapists emotional response to the client based on therapists past experiences.

Understanding Borderline language

- Stay warm and steady. Be curious
- Tolerate their distress and your discomfort.
- What are they asking for?

Containment – Admission vs support and self enablement

Connection/Validation – Support and self enablement

Control – Support and self enablement (enhance internal control agency)

. Under promise but deliver

. Repeat (regular appointments help contain crisis presentations)

. Maintain your psychological “core” (values, goals, boundaries)

What to do

- Address suicidality
- Address sabotaging behaviours – acting out behaviours, substance use, compliance with medications, appointments
- Encourage regular sleep and day routine, exercise, diet
- Arrange for follow up, judicious use of medications
- Encourage engagement with psychotherapeutic process.

Treatments and referral slides

- Medications?
- Supportive counselling, CBT, family therapy?
- Social, vocational and accommodation support?
- mental health team, hospital admission?
- BPD specific Psychotherapy: which one?

Medications: General issues

- Modest (at best) benefit for Axis I (**no cure**)
- Meaning of prescribing = showing care = placebo
- Symptom chasing (to help: their need, our need)
- Misuse
- Compliance is meaningless – why?
- Collaborative prescribing better than unilateral
- Which psychiatric medications are worse?
- Don’t unilaterally stop psych meds – why?

Biggest problem with medication!

- not learn new behaviour

Medications: Specific

- SSRIs/tricyclics
- Mood stabilisers
- Antipsychotics
- Benzodiazepines

- Best evidence short term Sx relief =

Sedating A/P's (+/- lamotrigine)

No evidence for changing trajectory of illness!

- Supportive counselling, CBT, family therapy?
- Social, vocational and accommodation support?

What about psychiatric system?

(also no evidence !)

- mental health team: crises, sharing risk, occasionally psychotherapy
- Private psychiatrist?
- hospital admission: when and why?
- ECT for depression in bpd?

What about usual psychotherapy?

- CBT
- Psychodynamic or psychoanalytic
- Couple or Family therapy
- PTSD therapy: prolonged exposure, EMDR

BPD specific Psychotherapy: changes trajectory…

Requires:

- **Minimum:** weekly x 1 year
- Emotion focused
- Actively explores suicidal ideas and DSH
- Active engagement, warmth (not therapeutic neutrality)
- Flexible, negotiated boundaries (not rigid)
- Equally efficacious!

Psychotherapy: specific models

1. from CBT = DBT (dialectical behaviour therapy)
2. From psychodynamic = conversational model, MBT (mentalization-based therapy)
3. Hybrid = schema focused therapy (individual or group)

Accessing psychotherapy

- Major problem = 10 session mental health plan not treatment
- Afford $100 per week: small list of private providers (bigger list with digital therapy?)
- Can’t afford: possible small role with psychotherapy psychiatrist, psychotherapy GP, CMHT, NDIS, VOCAL….

Not Willing for Psychotherapy

- GP for medication
- GP/Mental health team for crisis and support
- Family education and support
- Await “reason to live”

What can you do?

- Repeated **emotional focus and responsiveness** = builds emotional bond
- Manage medication and physical health (even if it is primarily dev. emotional bond)
- Help in crises
- Refer for BPD adapted psychotherapy

Suicide risk/Medicolegal

- Acute versus chronic suicidal ideation
- Frequent/lengthy hospitalization increases long-term risk (why?)
- Will need short-term risktaking for long-term benefit
- Risk-taking easier when therapeutic relationship (psychotherapy, engaged with you in an emotionally focused way)

Prognosis

- Surprisingly good prognosis
- Long-term follow-up studies with no intervention organized showed big reductions in impulsivity and crisis behaviour
- With treatment, better outcome than schizophrenia and bipolar disorder, anorexia nervosa or severe/chronic anxiety disorders!