

New findings on Borderline Personality Disorder : a research update

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Today

- What is new - hot topics and studies 2008-9
- Current debates



BORDERLINE PERSONALITY DISORDER

THE NICE GUIDELINE ON TREATMENT AND MANAGEMENT

NATIONAL
COLLABORATING
CENTRE FOR
MENTAL HEALTH

NICE clinical guideline 2009

- 557 pages
- Don't exclude from ANY services
- Encourage active choice in decision making
- Involve families and carers
- Promote optimism and hope around treatment
- Promote non-judgemental attitudes

- Monitor post-assessment reactions e.g. to disclosures of trauma
- Manage termination and transfer carefully
- Staff should have access to training and support
- Develop comprehensive care plans
- Twice a week treatment
- Not less than 3 months duration
- Attend to special groups and problems: co-morbidities (e.g. eating disorders, dual diagnosis, learning disabilities, literacy levels, young people)

- Pharmacotherapy should not be used, except for comorbid conditions
- Inpatient care should only be for crises with high risk to self or others
- Treatment should be delivered by specialist teams
- DBT, mentalisation-based therapy, transference-based therapy, cognitive analytic therapy, schema therapy, CBT
- More research is required

Hunter DBT study

- Australian and New Zealand Journal of Psychiatry – in press, Carter, Wilcox, Lewin, Conrad, Bendit
- DBT (group, individual and telephone) vs 6 mo TAU (wait-list for DBT)
- Full randomisation (no blocking) – no baseline differences
- 73 females, must have deliberate self-harm (at least 3 in past 12 months)
- 6 month study

Outcomes

DBT = TAU

- Hospital admissions, length of stay
- Rates of deliberate self-harm

DBT > TAU

- Less days 'in bed'
- Greater physical and psychological quality of life (WHO-QoL)

Issues

- Important replication of Linehan in Australia
- All groups showed clinical improvement
- Independent measures of hospitalisation
- Variances in sample might have obscured results (issue of randomisation)
- TAU intensity, Duration (6mo), DSH rates (75%) unexpected

- “Outcome trajectories of personality disordered patients during and after a psychoanalytic hospital-based treatment”
- Vermote, Fonagy et al 2009 Journal of Personality Disorders, 23 (3) 294-307

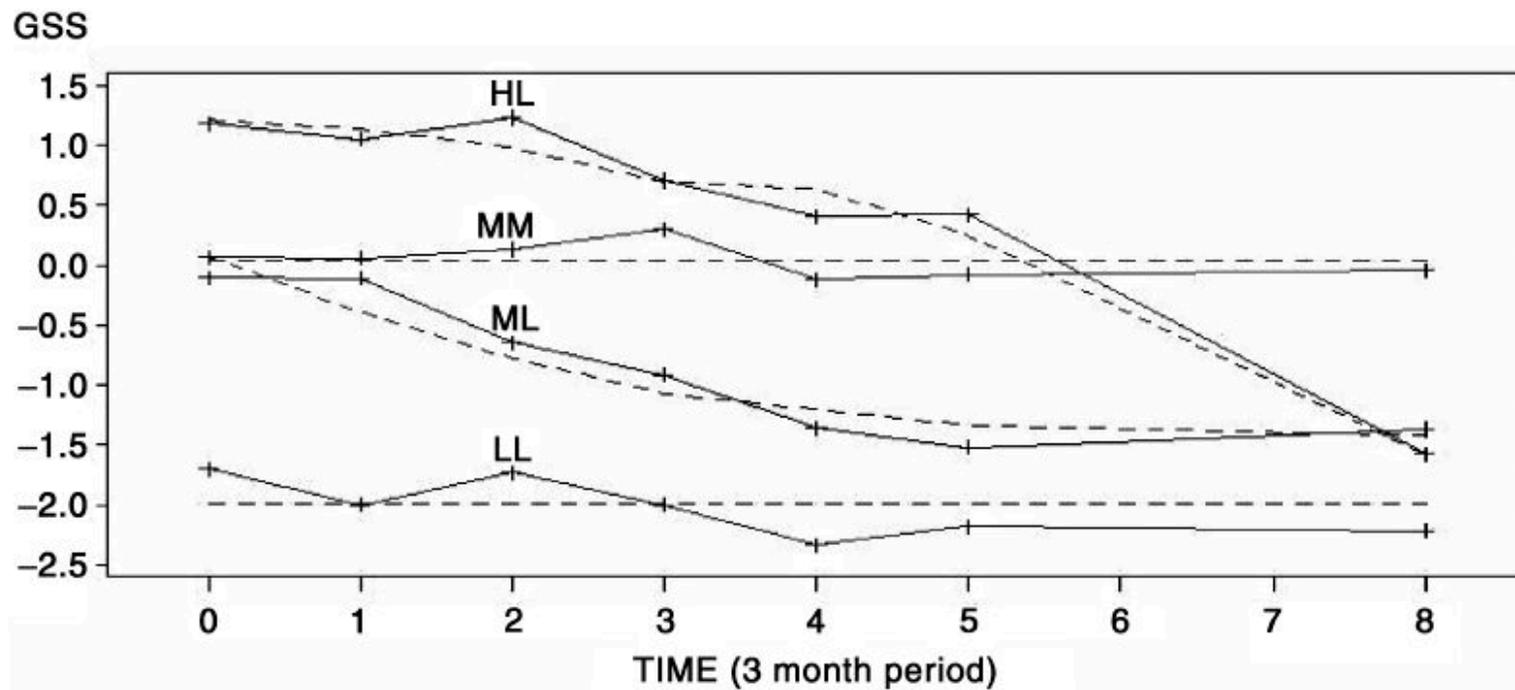


FIGURE 2. Four trajectories model of the Global Symptom Score (GSS) during treatment (Time 0–4) and follow-up (Time 5–8). The dotted lines present the trends. GSS is shown on the Y-axis, and Time on the X-axis (0 refers to start of treatment; 4 to 12-month treatment, 5 to 3-month follow-up, and 8 to 12-month follow-up).

HL High-Low group – HL = high on avoidant and depressive, highest trauma, high self-harm
 MM Medium-Medium group - MM = higher trauma, greater
 ML Medium-Low group – ML introjective
 LL Low-Low group – LL = least severe personality disordered group

Key issues

- No groups improved in first three months
- Intense sustained containment of symptoms within partial hospitalisation (day patients, 3 groups a week, individual therapy, non-verbal creative therapies, nurse group and individual meetings and staff-patient meetings) – most effective for the most disordered, depressed and avoidant, self-harming high risk patients (HL group)

Key issues

- ML group was introjective – self-definition, self-critical patients – they responded best to the psychoanalytic insight oriented approach
- MM group showed treatment resistance – least improvement – were more anaclitic in orientation – emphasising relationships as primary - did not respond as well to insight focus – also had high trauma histories

- “Affective instability: Measuring a core feature of Borderline Personality Disorder with ecological momentary assessment”
- Trull et al (2008) J Abnormal Psych 117(3) 647-661

Method

- Comparison of BPD patients with depressed patients
- Continuous monitoring of mood (ecological momentary assessment)
- Palm pilot prompted 6 times a day to complete mood questionnaire, over 28 days
- Assessment times randomised within and between patients

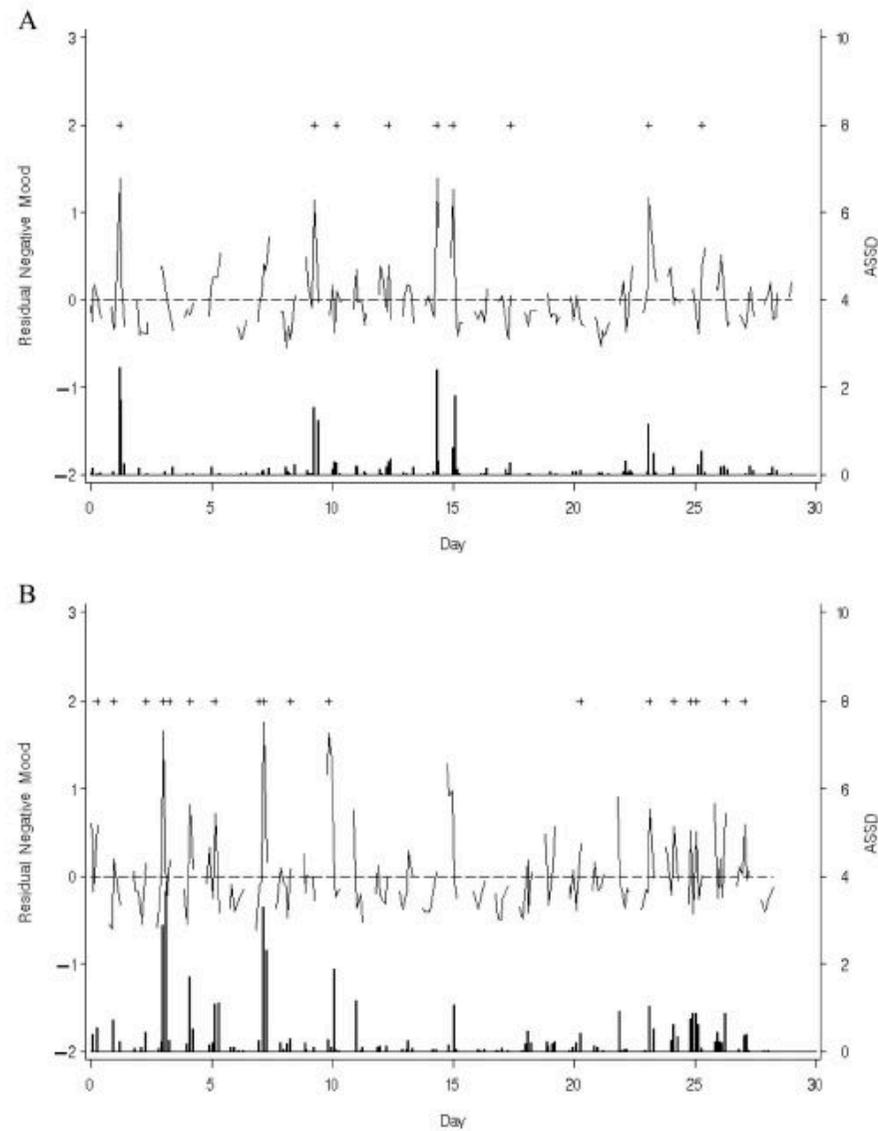


Figure 3. A: Detrended Negative Affect (NA) scores for the study participant with current major depressive disorder ($n = 157$ measurement occasions). B: Detrended NA scores for the study participant with borderline personality disorder and affective instability ($n = 156$ measurement occasions) referred to in Figure 1. Solid lines indicate residual NA scores after detrending (gaps between solid lines represent between-day assessments for which the successive differences are not considered in the analysis); dashed line indicates the mean residual NA score over all measurement occasions; bars above baseline indicate the adjusted squared successive difference score for residuals between the current and the previous occasions; and plus symbols indicate those occasions in which the adjusted successive difference in residual NA was greater than or equal to the 90th percentile of the adjusted successive difference in residual NA scores in the entire sample.

Key Points

- affective changes in BPD were:
 - abrupt
 - large in magnitude
 - likely brought on by external (and thus less predictable) events.
- BPD – higher fluctuation in positive affect
- BPD – higher hostility spikes

Recent debates

- Mulder, 2009 “Is Borderline Personality Disorder really a personality disorder?”
Personality and Mental Health 3:85
- Is BPD really an unstable mood disorder, and not a personality disorder?
- DSM-V – issue of dimensional vs categorical

Other hot topics...

- Shame – Rusch Arch Gen Psych – high in BPD -> poorer quality of life and self-esteem and greater anger-hostility
- Aggression – Critchfield J Clin Psychol – Interaction between attachment style and expectation of rejection – Cues hostility, irritability and aggression

BPD vs PTSD

- Borderline Personality or Complex Posttraumatic Stress Disorder? An Update on the Controversy
- Lewis and Grenyer 2009 Harvard Rev Psychiatry 17:322–328

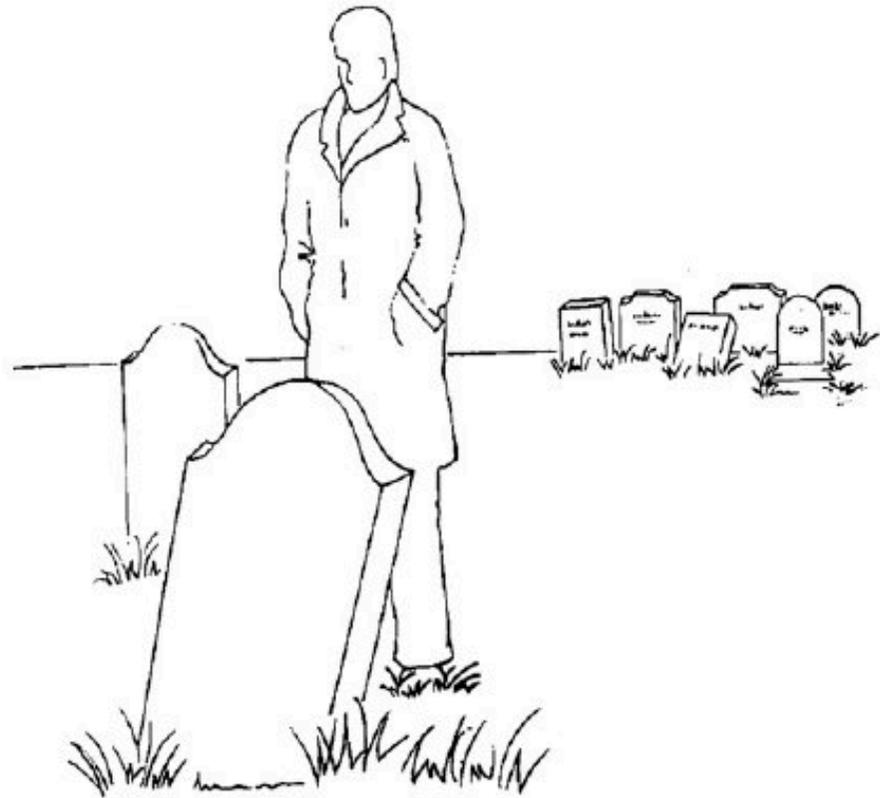
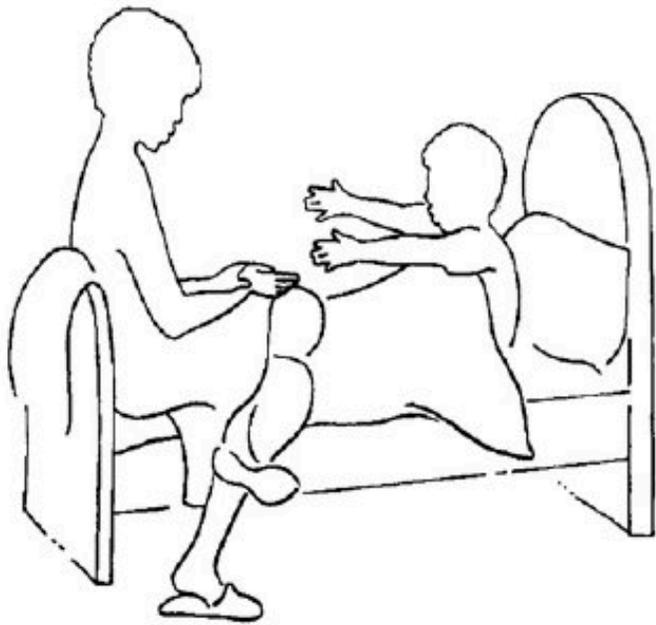
Key points

- Risk vs causation – chronic trauma increases risk of BPD but not essential
- Trauma involved in multiple disorders, some more than BPD e.g. depression, substance abuse
- Treatment trajectories are different – CBT exposure vs. long term affect-focused therapy

- “Neural correlates of attachment trauma in borderline personality disorder: A functional magnetic resonance imaging study”
- Buchheim et al 2008 Psychiatry Research: Neuroimaging 163, 223–235

fMRI scanning

- 11 BPD vs 17 Controls
- Telling of individual stories in relation to attachment pictures
- Single person pictures : BPD activated anterior midcingulate cortex (pain/fear)
- Dual person pictures : BPD activated right superior temporal sulcus (hypervigilance) and less activation of the right parahippocampal gyrus (memory valence)



Key differences

- Cemetery:
- BPD: described isolation, abandonment, murder, suicide, and dissociated imagery (e.g., figures floating above the ground).
- Controls: described typical graveyard contact with the deceased (visit) or grief talk.

Key issues

- Differences between pictures : Intolerance of aloneness – differentiated groups
- BPD: hypersensitive attention to the social environment
- Poor contextualization of positive relationship
- Neural mechanisms of attachment trauma underly interpersonal symptoms of BPD

Future work:

- Current research activity is on particular features of BPD e.g. affect, emotions, trust, self-harm
- Studies of actual work satisfaction, love, social relationships and creativity over long term needed
- Studies of neurobiological processes (deep and cortical integration) needed to understand improvement and deterioration