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Specialising in Personality Disorder and Complex Trauma

BPD A treatable disorder with good prognosis

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Director, Spectrum
1st December 22
DY Patil Medical School
DY Patil Lecture Series
Mumbai, India

Eastern Health

- Thank you for inviting me to speak at your DY Patil Lecture Series

- Special thanks to Prof Cholera

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Introduction

- The science of personality disorder has taken centre stage in mental health during the last two decades.
- Personality disorders are the most stigmatized, misunderstood and underdiagnosed conditions in psychiatry
- A generation of mental health professionals have not been trained to treat and manage people with personality disorders.
- At present, evidence-based treatments are available only for borderline personality disorder.

Personality

Personality is a person's characteristic style of thinking, feeling and behaving

Personality Disorder
(DSM-5)

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*"A personality disorder is an **enduring pattern** of inner experience and behavior that **deviates markedly** from the expectations of the individual's culture, is **pervasive and inflexible**, has an onset in adolescence or early adulthood, is **stable over time**, and leads to **distress or impairment**"*

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Personality disorders

- Community-prevalence of 4%-11%
- 50% of psychiatric outpatients
- The highest prevalence in the criminal justice system
- High risk of suicide (10% of all suicides) (Rao et al 2019)
- ***Limited recognition as a public health issue***

Grenyer et al 2017

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DSM-5 personality disorders

Cluster A (odd-eccentric cluster)

1. Paranoid
2. Schizotypal
3. Schizoid

Cluster B (dramatic-emotional cluster)

1. **Borderline**
2. Narcissistic
3. Histrionic
4. Antisocial

Cluster C (anxious fearful cluster)

1. Avoidant,
2. Dependent
3. Obsessive-compulsive

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ICD 11- Personality disorder

- **Unitary diagnosis** of Personality Disorder

- Classify three levels of severity
    1. Mild Personality Disorder
    2. Moderate Personality Disorder and
    3. Severe Personality Disorder

- Can specify one or more prominent trait domain qualifiers:
    1. Negative Affectivity
    2. Detachment
    3. Disinhibition
    4. Dissociality and
    5. Anankastia

- Additionally, one can specify a **Borderline Pattern** qualifier.

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Vast majority of people with PD do not receive meaningful care or treatments

- ***In most countries we don't have mature models of care for people with personality disorders.***

- ***Vast majority of people with BPD do not receive meaningful care or treatments.***

Borderline Personality Disorder (BPD)

- Most commonly diagnosed PD
- Most severe PD
- Contributes to 95% of all PD suicides (Rao et al 2019)
- Highly stigmatised disorder

BPD clinical features

- BPD is characterized by **instability** of emotions, relationships and identity; impulsivity, emptiness, fear of abandonment, NSSI and suicidal behaviours, anger dyscontrol and micro psychotic episodes and dissociations.

- Some experience a chronic sense of emptiness, ***"identity-less-ness"*** (Zanarini, 1998)

DSM-5 Criteria for BPD

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

BPD is a highly stigmatized disorder

John Gunderson

“BPD is to psychiatry what psychiatry is to medicine”

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BPD Prevalence

- **1-2%** - Community prevalence (Trull et al 2010, Torgersen 2012).
- **15-20%** - Mental health systems(Zimmerman et al 2008,Korzekwa et al 2008)
- **10-15%** - Emergency presentations (Chaput 2007, Tomco 2014) .
- **6%** - Primary care (Gross et al 2002).

Resource allocation disparity

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Borderline Personality Disorder

- 20 year reduction in life span
- Suicide rate 10%
- Non-Suicidal Self-Injury (NSSI)- 85%

Gender Distribution

- Diagnosed predominantly in women- 75%

  (Schwartz, 1991).

- Men are under diagnosed in public mental health services and seen often in Drug and Alcohol services, prison settings

- **BPD impacts both genders equally** (Grant et al 2008)

Age of onset

- **BPD usually emerges during adolescence** (Chanen, 2009, Zanarini 2001)

- BPD presents across life stages

- **Late manifestation of BPD**
  (Jo et al 2022, Stevenson 2009, Bernstein et al 2002, Zanarini 2007)


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RESEARCH ARTICLE

Personality and Mental Health

Late manifestation of borderline personality disorder: Characterization of an under-recognized phenomenon

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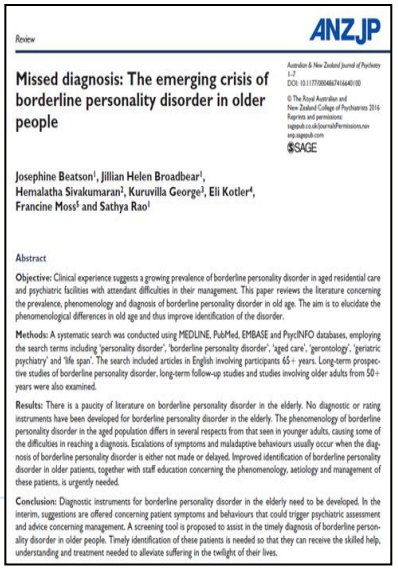
Abstract
Although uncommon, borderline personality disorder (BPD) may manifest for the first time later in life. A retrospective clinical file audit was used to identify the clinical manifestation of BPD for the first time at or above the age of 30, and to examine whether particular clinical and psychosocial factors may be associated with a later-in-life manifestation of BPD. Twenty-three cases of late manifestation BPD were identified. People with late manifestation of BPD had similar risk factors and vulnerabilities, including childhood trauma, to the broader BPD population. They were distinguished by having higher levels of education, employment, and long-term intimate relationships. Interpersonal problems, loss of employment and reminders of past sexual trauma were key precipitating factors. The findings underscore the legitimacy of a late-manifestation diagnosis of BPD by demonstrating that BPD does not present exclusively during adolescence and early adulthood. BPD may present for the first time in later life in response to loss of protective factors or triggering of past trauma. This understanding may reduce misdiagnosis or delayed diagnosis, prescription of inappropriate treatments or delays in receiving BPD-appropriate treatments.


Review

ANZJP

Missed diagnosis: The emerging crisis of borderline personality disorder in older people

Australian & New Zealand Journal of Psychiatry 1–7
DOI: 10.1177/0004867416641030

SAGE

Josephine Beatson[1], Jillian Helen Broadbear[1], Hemalatha Sivakumaran[2], Kuruvilla George[3], Eli Kotler[4], Francine Moss[5] and Sathya Rao[1]

Abstract

Objective: Clinical experience suggests a growing prevalence of borderline personality disorder in aged residential care and psychiatric facilities with attendant difficulties in their management. This paper reviews the literature concerning the prevalence, phenomenology and diagnosis of borderline personality disorder in old age. The aim is to elucidate the phenomenological differences in old age and thus improve identification of the disorder.

Methods: A systematic search was conducted using MEDLINE, PubMed, EMBASE and PsycINFO databases, employing the search terms including 'personality disorder', 'borderline personality disorder', 'aged care', 'gerontology', 'geriatric psychiatry' and 'life span'. The search included articles in English involving participants 65+ years. Long-term prospective studies of borderline personality disorder, long-term follow-up studies and studies involving older adults from 50+ years were also examined.

Results: There is a paucity of literature on borderline personality disorder in the elderly. No diagnostic or rating instruments have been developed for borderline personality disorder in the elderly. The phenomenology of borderline personality disorder in the aged population differs in several respects from that seen in younger adults, causing some of the difficulties in reaching a diagnosis. Escalations of symptoms and maladaptive behaviours usually occur when the diagnosis of borderline personality disorder is either not made or delayed. Improved identification of borderline personality disorder in older patients, together with staff education concerning the phenomenology, aetiology and management of these patients, is urgently needed.

Conclusion: Diagnostic instruments for borderline personality disorder in the elderly need to be developed. In the interim, suggestions are offered concerning patient symptoms and behaviours that could trigger psychiatric assessment and advice concerning management. A screening tool is proposed to assist in the timely diagnosis of borderline personality disorder in older people. Timely identification of these patients is needed so that they can receive the skilled help, understanding and treatment needed to alleviate suffering in the twilight of their lives.

Co existing disorders

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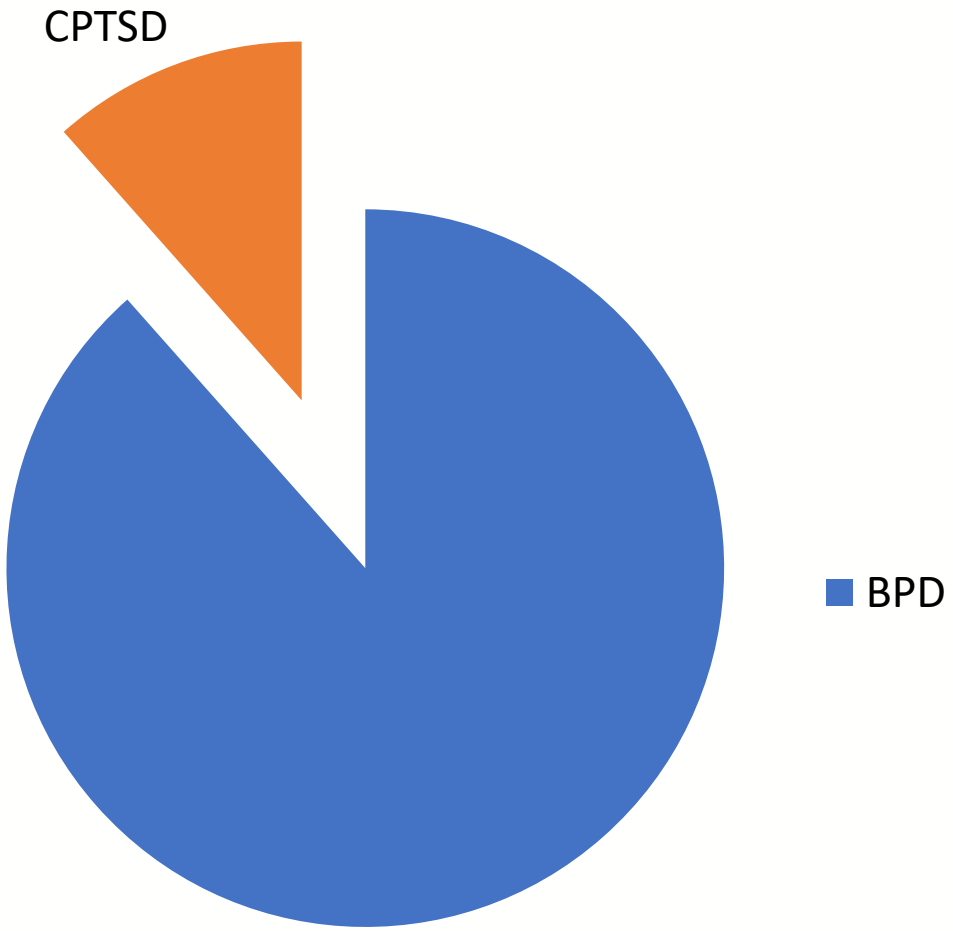
"BPD is the King of comorbid kingdom"- P.Tyrer

- Norm rather than exception
- Only 5 % present in pure form
- Depression 75%
- Substance abuse 62%
- Other Personality disorders 90%
- Bipolar disorders,
- Psychosis-Schizophrenia
- Eating disorders
- PTSD, OCD or Anxiety disorders- 89%
- Dissociative disorders, ADHD, DID
- Gambling

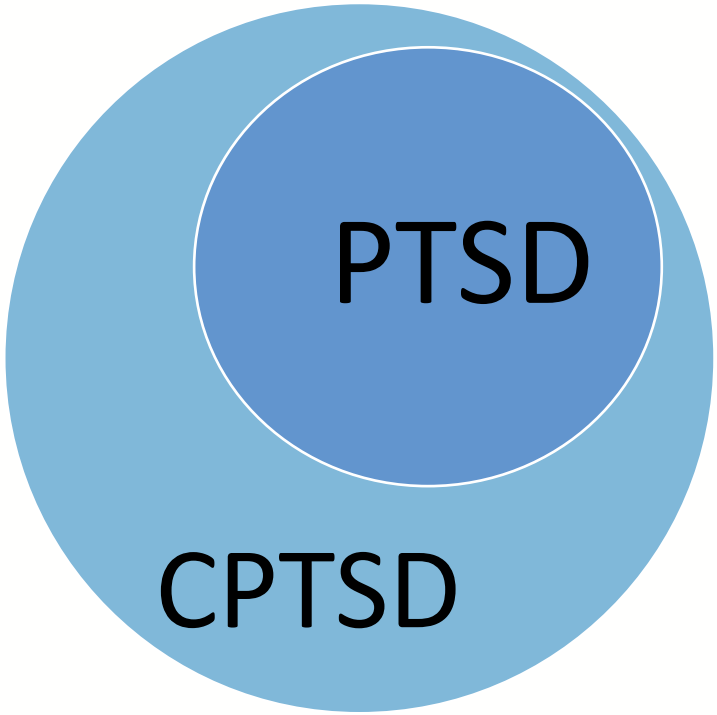
Myth: BPD is caused by trauma and is a trauma disorder.

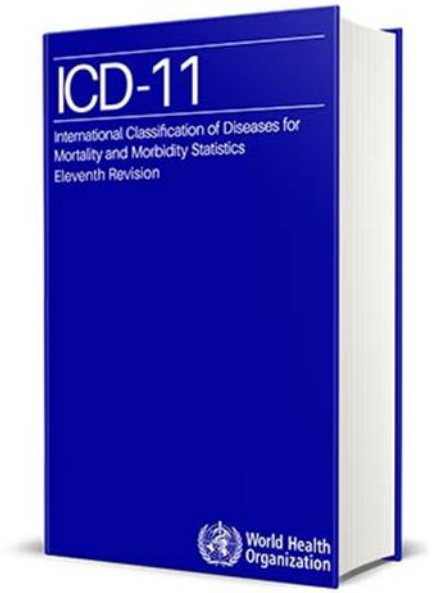
Lets rename it as Complex Trauma Disorder or CPTSD

CPTSD was subsumed under BPD until ICD 11



CPTSD





CPTSD = PTSD + Disturbance of Self Organisation (DSO)

1. Emotion dysregulation
2. Interpersonal difficulties
3. Negative self concept

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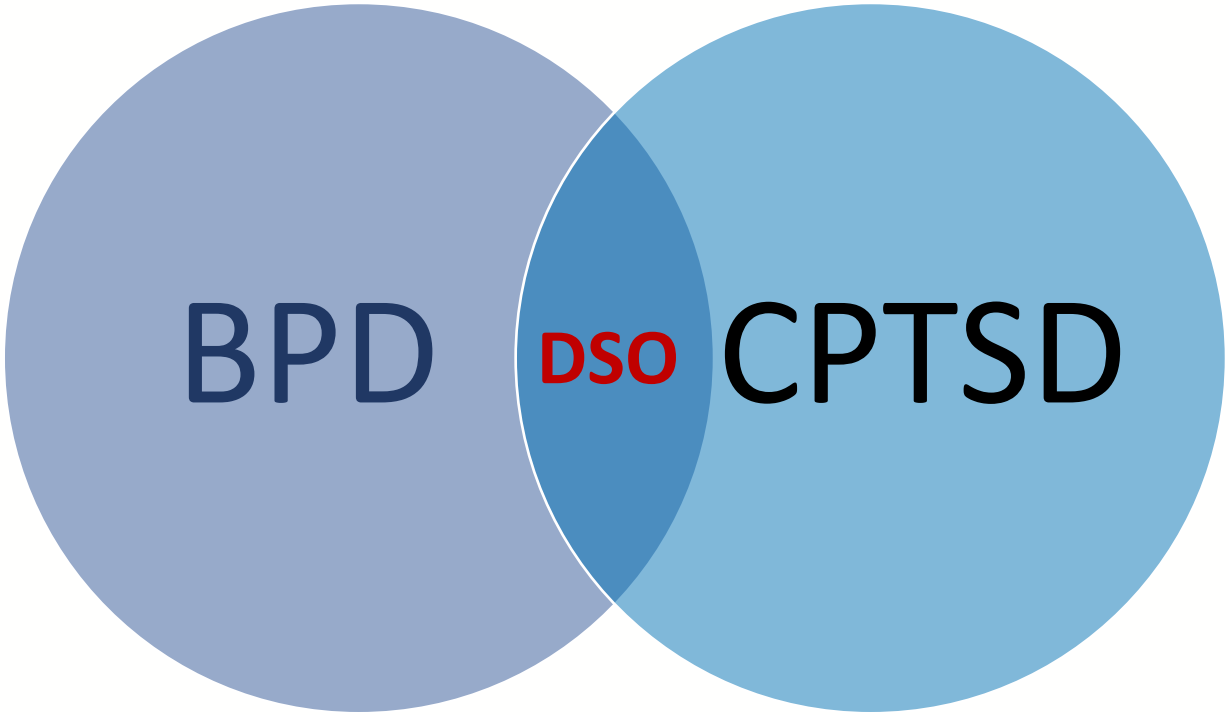
Disturbance of Self Organisation (DSO)

1. Emotion deregulation 2. Interpersonal difficulties 3.Negative self concept



- 50% of people with BPD have CPTSD
- 8% of people with CPTSD have BPD

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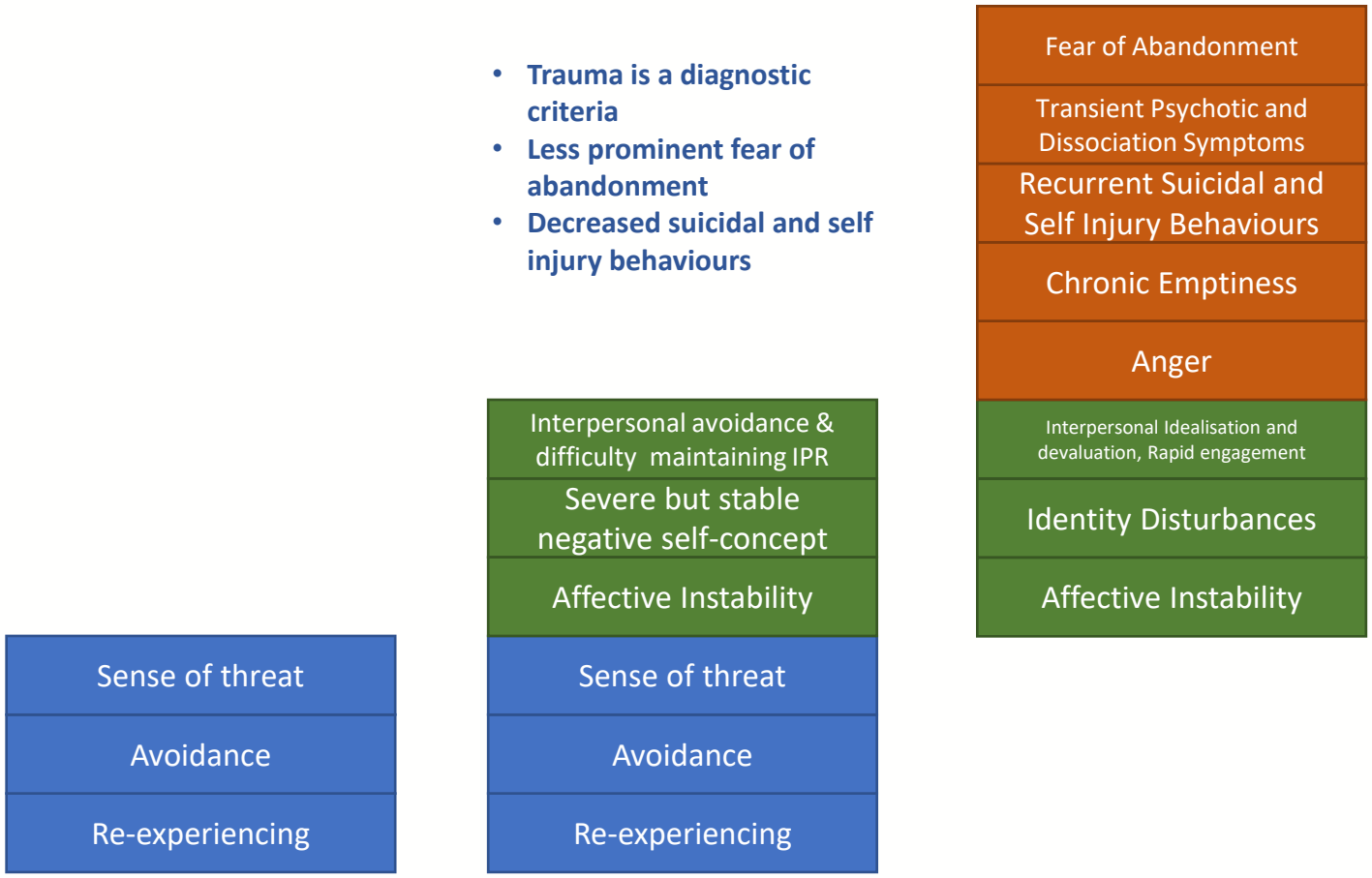
PTSD, Complex PTSD and BPD

- **Trauma is a diagnostic criteria**
- **Less prominent fear of abandonment**
- **Decreased suicidal and self injury behaviours**



Ref: European Journal of Psychotraumatology 2013, 4:20706 and DSM-5

What causes BPD?

- Up to 85% of people with BPD report a history of trauma

- Up to 10% of people with BPD report no significant childhood traumatic experiences or attachment difficulties

- Attachment problems are common in BPD

What causes BPD?

- Environmental factors (attachment, trauma, bullying etc.) may all contribute to development of BPD

Trauma is very common- risk factor- but not essential for development of BPD

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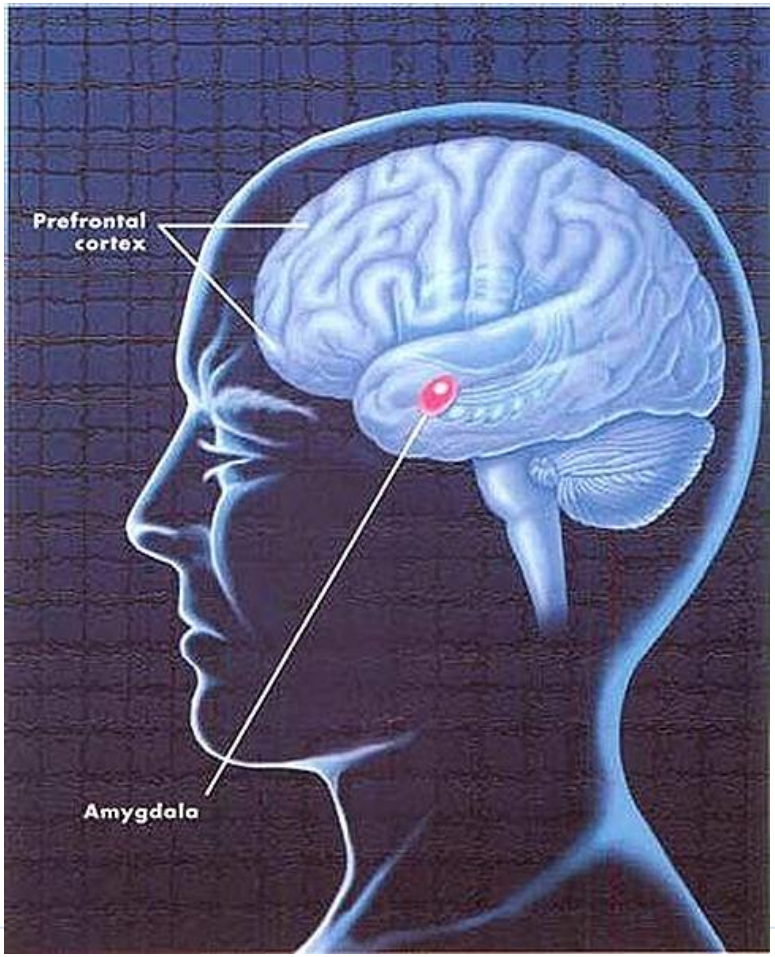
Biological abnormalities

- 50% heritability
- Amygdala- hyperactive
- Poor cortical control over amygdala
  (Abnormal Cortico-limbic system)
- Profound incapacity to co-operate due to **anterior insula** abnormality

Prefrontal cortex has less control over Amygdala



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If we compare the emotional system of BPD to a car, then the person with BPD is driving a car with a hypersensitive accelerator and poor brakes

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Demand is for the clinician to be an empathic instructor

Clinician

Patient

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“Having BPD is not the persons own fault. It is a disorder of the brain and the mind”

(National Health and Medical Research Council 2012).

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“These patients can be difficult to treat,

but

it is the illness that produces the behaviour, not the person“

-Oldham

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BPD Suicides in Victoria (2009-2013)

(Spectrum – Vic Coroners Court study 2018)

- **99%** of them had passed through public mental health services in the preceding 1 year
- **88%** made contact with public mental health services in the last 6 weeks
- **25%** of them had presented to ED's in the preceding 6 weeks prior to death.
- **18-64 years of age- 95% of all BPD suicides**

Treatment of BPD

- No medications are patented or indicated

- Psychotherapy is the treatment of choice

Validation

- Its not about the nail:
- https://www.google.com/search?q=its+not+about+the+nail&rlz=1C1GCEB_enAU913AU914&oq=its+not+about+the+nail&aqs=chrome..69i57.7924j0j4&sourceid=chrome&ie=UTF-8

Specialist Treatments for BPD

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Treatments	Originators	Validation Study
Dialectical Behaviour Therapy (DBT)	Marsha Linehan	Linehan et al., 1991
Mentalization Based Therapy (MBT)	Peter Fonagy, Mary Target, Anthony Bateman	Bateman and Fonagy, 1999
Schema Focused Therapy (SFT)	Jeffrey Young	Giesen-Bloo et al., 2006
Transference Focused Psychotherapy (TFP)	Otto Kernberg	Clarkin et al., 2007
Systems Training for Emotional Predictability and Problem Solving (STEPPS)	N Blum	Blum et al., 2008
General Psychiatric Management	John Gunderson	McMain et al., 2009
Cognitive Analytic Therapy	Anthony Ryle	Chanen et al., 2009
Cognitive Behaviour Therapy	K Davidson	Davidson et al., 2006

Australian contributions to treatment of BPD

Treatments	Originators	Validation Study
The Conversational Model	Russell Meares	Meares et al., 1999
Acceptance & Commitment Therapy (ACT)	Steven Hayes	Morton et al., 2012

Generalist treatments

- Structured Clinical Management (SCM)-Bateman and Kravitz 2013
- General psychiatric management (GPM)- Gunderson 2001
- Good Clinical Care (GCC)- Chanen
- Supportive Psychotherapy (SP)- Clarkin et al 2007, Rockland 1992
- Integrated Treatment (Livesley 2016)

They are all equally effective and as effective as specialist treatments.

More commonalities than differences between specialist and generalist treatments and each other

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Examination of common factors

1. Common factors in empirically supported **specialist treatments** for BPD (DBT, MBT etc.)

2. Common factors in empirically supported **generalist treatments** for BPD (SCM)

3. NHMRC guidelines (2012)

4. International Expert opinion:
   - Bateman and Fonagy (2000)
   - Gunderson and Links (2008)
   - Paris (2008)
   - Zanarini (2008) and
   - Weinberg (2011)
   - Livesley (2005)

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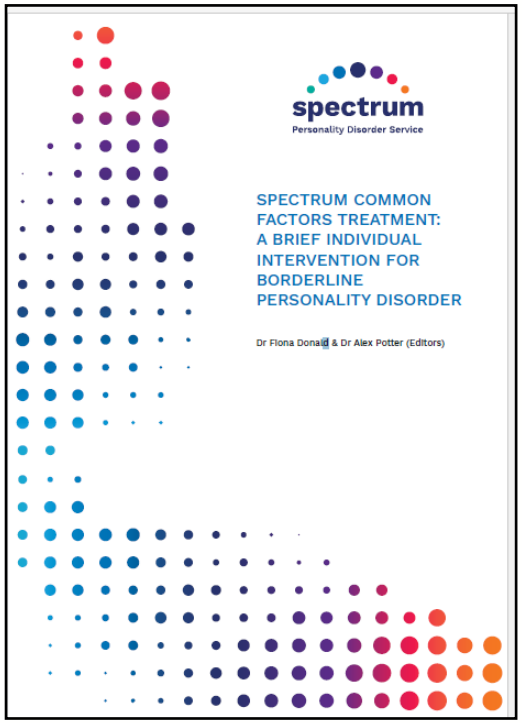
Integrated, common factors based, stepped care treatments that are adapted to Australian mental health systems are the way to go.

10, 20 session treatment



https://www.spectrumbpd.com.au/images/Spectrum_Common_Factors_Treatment_A_Brief_Individual_Intervention_For_Borderline_Personality_Disorder.pdf

10-week Intensive (80 hours) Group Program (IGP) for BPD: making the case for more accessible and affordable psychotherapy

	Time 1 (%) n=43 12 months prior to program	Time 2 (%) n=43 Since commencing treatment (10 weeks)	P
Self-harm (Y/N)	26 (59.1)	17 (38.6)	.039
Suicidal ideation (Y/N)	37 (84.1)	30 (68.2)	.180
Suicidal behaviour (Y/N)	13 (29.5)	2 (4.5)	.006

10 week intervention was successful in reducing self-harm and suicidal behaviour over the ten weeks of the program.


Forensic psychiatry

ORIGINAL RESEARCH

Ten-week Intensive Group Program (IGP) for borderline personality disorder: making the case for more accessible and affordable psychotherapy

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Prognosis

- Psychotherapy WORKS!
- Most patients can get well
- Many recover
- Most stop wanting to kill themselves
- ***BPD is a good prognostic disorder contrary to previous beliefs***

Summary-outcome studies

- 10% remission in 6 months
- 25% remission in 1 year
- 45% remission in 2 years
- 85% remission in 10 years
- 60% recovery in 16 years

- **15% relapse rate**
- ***Severe and persistent impairment in social functioning***

(Gunderson 2011, Zanarini 2016)

Prognosis with treatment

- MBT- 60% remission by 1 year.
- GPM – 65% remission by 2 years
- DBT- 60-80 % remission by 1 year

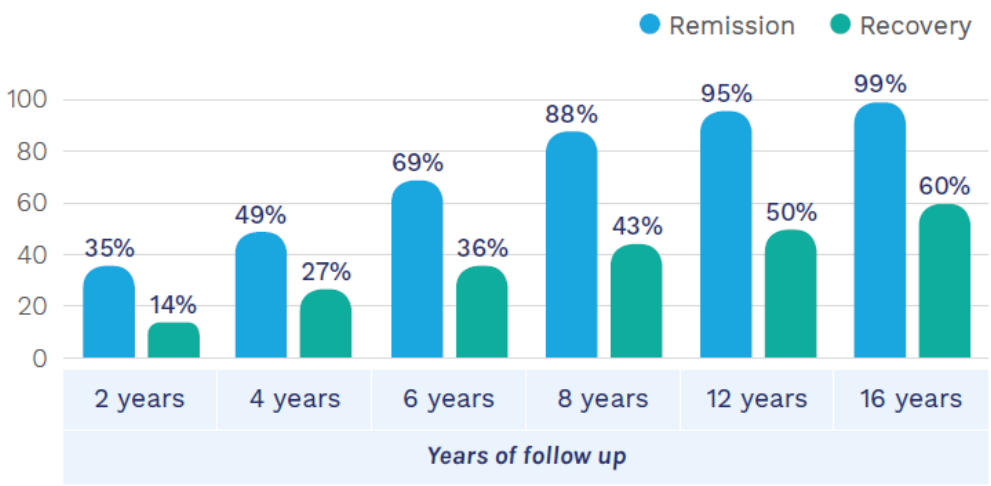
Specialist treatments hasten remission and recovery

Remission and Recovery

(Zanarini 2012)

Years of F/U	Remission	Recovery
2 years	35%	14%
4 years	55%	27%
6 years	76%	36%
8 years	88%	43%
10 years	91%	47%
12 years	95%	50%
14 years	97%	56%
16 years	99%	**60%**

Table 3: *Remission and recovery from BPD*[7]



Remission

defined as no longer meeting DSM criteria for BPD for 2 years or longer.

Recovery

defined as remission of BPD and having at least one emotionally sustaining relationship with a close friend or life partner/spouse and be able to work (including domestic duties) or go to school consistently, competently and on a full-time basis.

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Is there a pill for BPD?

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NO DRUG IS LICENSED OR INDICATED FOR TREATMENT OF BPD

Medications

- ***25% patients attempt suicide with prescribed medications*** *(Makela 2006)*

- Medications- only 20% intensity of symptoms reduced

- Medications should be used sparingly and rationally

Medications commonly used in practice

- Very limited data to support the following- but not a whole lot!
- **Quetiapine**- 25 to 150 mg/day- crisis management (Lee et al 2016, Black et al 2014)
- **Topiramate** (200mg/day) and **Lamotrigine** (50-100 mg/day) are reported to be effective against anger, aggression and mood instability.
- **Aripiprazole** (2.5-5 mg/day) is effective against anger, aggression, depression, paranoid thinking, anxiety and interpersonal sensitivity
- **Fluvoxamine** (200 mg/day) is effective in controlling rapid mood shifts.

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Medications commonly used in practice

- Selective serotonin reuptake inhibitors (SSRIs), such as Fluoxetine, appear to have some beneficial effect on mood instability, anger and impulsivity.

- Low-dose atypical antipsychotics (Olanzapine) have some positive effect on impulsivity, aggression, interpersonal relationships, depression and global functioning.

Omega-3 fatty acids

- UltraClean- 4 caps/day -1200 EPA + 800 DHA)

(EPA- Eicosa Pentanoic Acid- 300 mg per cap, DHA- Docosa Hexanoic Acid- 200 mg per cap)

- Can reduce depression and aggression. The safety of this drug in pregnancy makes it an attractive option (Zanarini 2003)
- Might reduce the overall severity of BPD (Zanarini 2004)

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- Amygdala modulating agent?
- Psychedelics?
- TMS?
- Deep Brain stimulation?
- Gene editing- CRISPR?

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Can interested clinicians provide treatment (psychological) for BPD if they are not trained in one of the specialist BPD therapies?

Best Practice Guidelines for BPD

- NHMRC Clinical Practice Guidelines for BPD- 2012
- British NICE Guidelines
- APA Guidelines
- European Guidelines (Simonsen et al 2019)
  - Swedish
  - Swiss
  - Danish
  - Finnish
  - Catalonia
  - German
  - Dutch
- Australian local guidelines (Grenyer 2015, Spectrum 2020)

ESSENTIALS
(caring for people with BPD)

- Help them get well-**psychotherapeutic** treatments
- Help them manage distress and keep alive -structured **crisis interventions**
- Help them with treatments for **co-occurring disorders**
- Help them improve their **physical health and well being**
- Help them improve quality of life- **jobs and relationships**
- Educate and support **families and carers**

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" If you know enough to avoid being harmful, you can surprisingly be very helpful"

- Gunderson and Links (2014)

Key to successful treatment with therapy

Therapists need to reflect on their own emotional reactions (counter-transference)

Central principles to hold in mind

- The most important ingredient of effective treatment for BPD is an ***ongoing therapeutic relationship*** with a clinician

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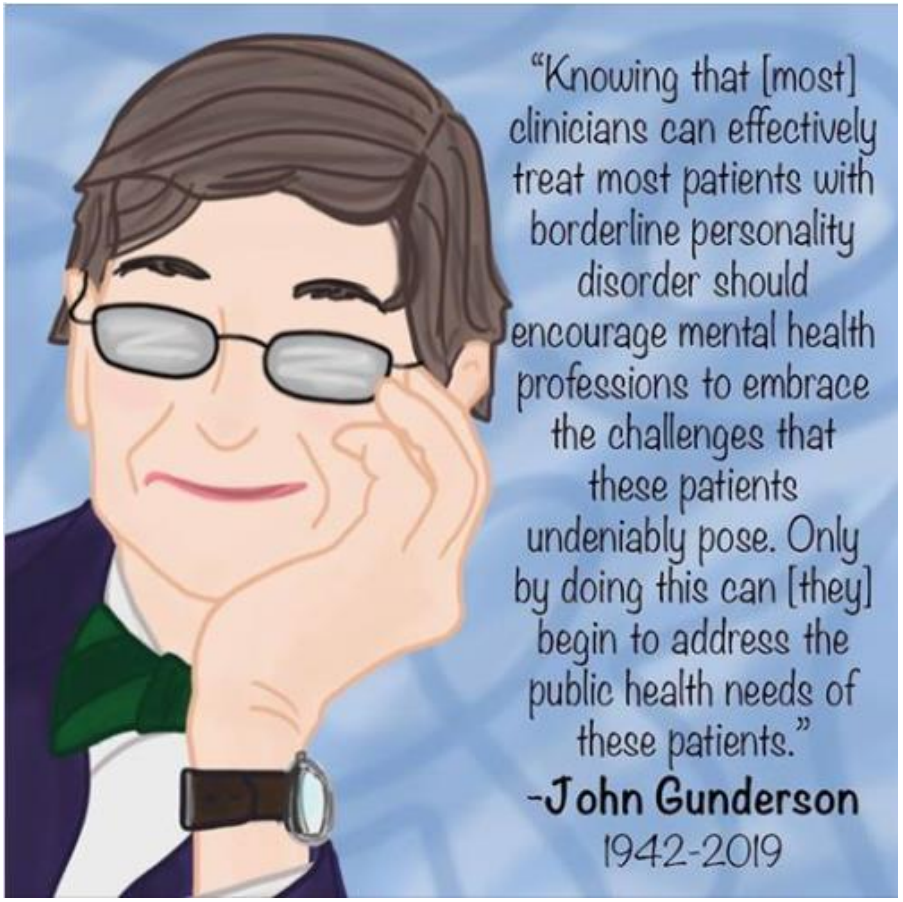
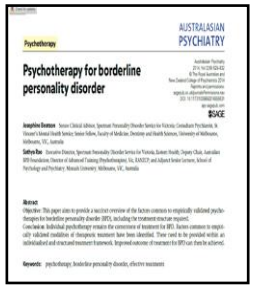
YES, all of you CAN do psychotherapy for BPD and it is not rocket science



"Most clinicians can effectively treat most patients with BPD"

"Effective psychotherapeutic treatment for BPD can be provided by clinicians who lack specific training in psychotherapies"



AUSTRALASIAN PSYCHIATRY

Psychotherapy

Psychotherapy for borderline personality disorder

Essential treatment principles

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- Diagnosis of BPD and its comorbidities
- Assessment of risks
- Understanding why they self harm
- Joint crisis management plan
- Psychoeducation to patient and family
- Setting up the contract for care
- Avoid hospitalization as much as possible
- Judicious use of medications

Essential treatment principles

- Collaborative approach and consensus on how to achieve the goals
- Balancing **validation** and **change**
- Change focused interventions: Skills to regulate emotions, manage crisis, IP dynamics etc.
- **Focus on emotions- (clinicians and patients)**
- Help them to connect their actions with feelings
- Fostering self responsibility-treat them like adults- don't treat them as fragile

Essential treatment principles

- Pay attention to therapeutic relationship
- Seek supervision- speak to your colleagues
- Clinicians who are trained, active, willing, hopeful, enthusiastic seem to do well with BPD
- Encourage patients to **'get a life'**
- Improve functionality- work, relationships

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JACOBS

- **Ju**mping in to conclusions
- **A**ssumptions
- **C**atastrophising
- **O**vergeneralisations
- **B**lack and White Thinking
- **S**houlds and Musts

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Rules of assessment and management of suicide is very different in BPD compared to other psychiatric disorders

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Acute and Chronic Suicidality

- ***Acute suicidality** refers to suicidal ideas or acts with the aim of death.*

- ***Chronic suicidality** is any suicidal act or threat which is repetitive in nature but does not aim to end life.*

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Suicidality and NSSI

Often BPD patients are unaware if they are acting on a suicidal impulse or self injuring to regulate their internal or external world

(Paris 2007)

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There is no science to help us distinguish NSSI behaviours from suicidal behaviours

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Spectrum Matrix Method of Risk Analysis

Most BPD patients seem to follow a pattern of self injury and chronic suicidal behaviours

(w.r.t. method, frequency and severity of self injury and chronic suicidal behaviours)

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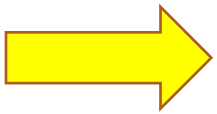
Pattern of chronic suicidal behaviours

Chronic pattern



Change in the chronic pattern

Self Harm / Chronic Suicidality

- High lethality acts (CO poisoning, hanging)
- Low lethality acts (cutting, minor OD)

- Chronic pattern
- Change in chronic pattern

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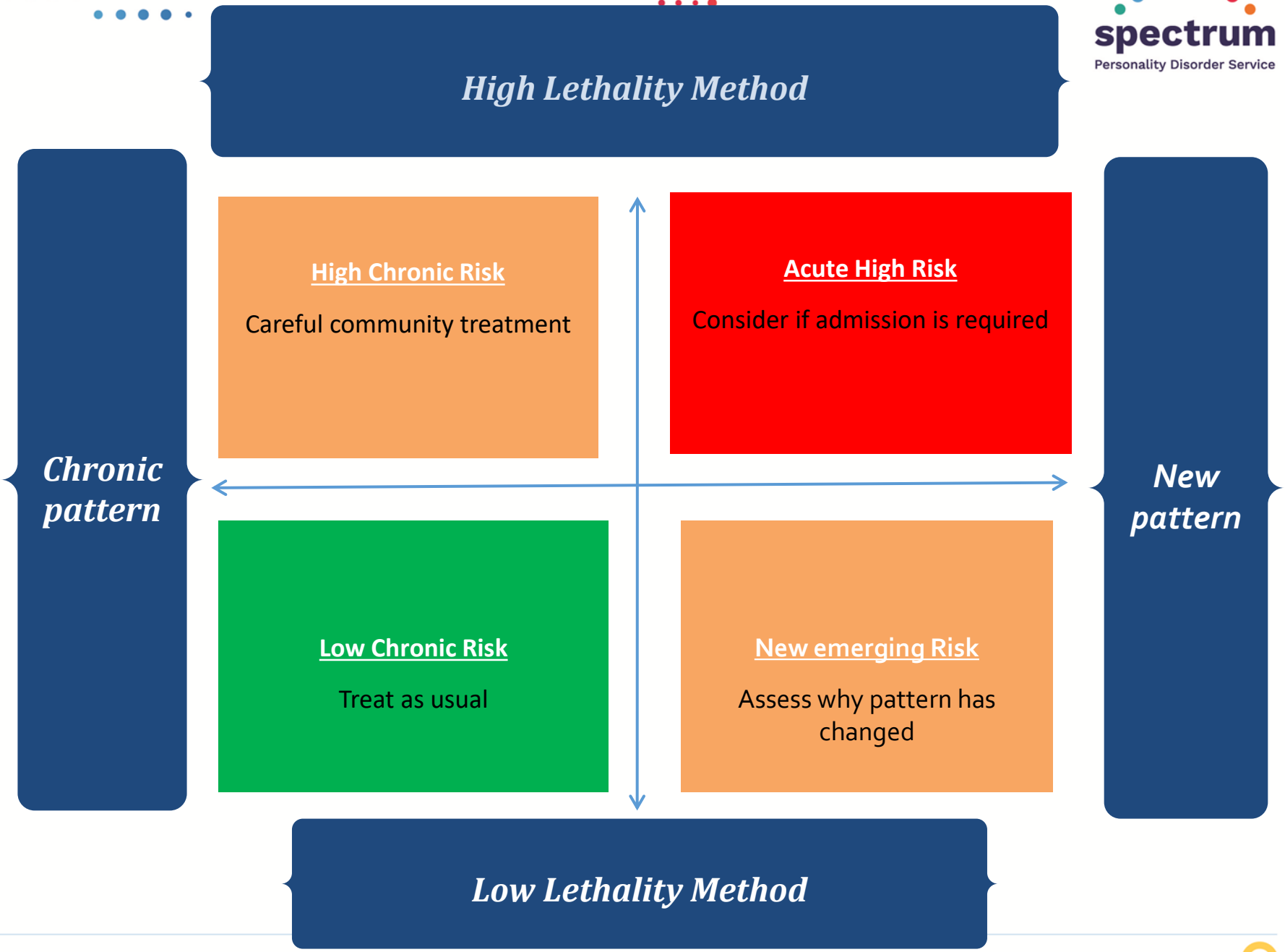

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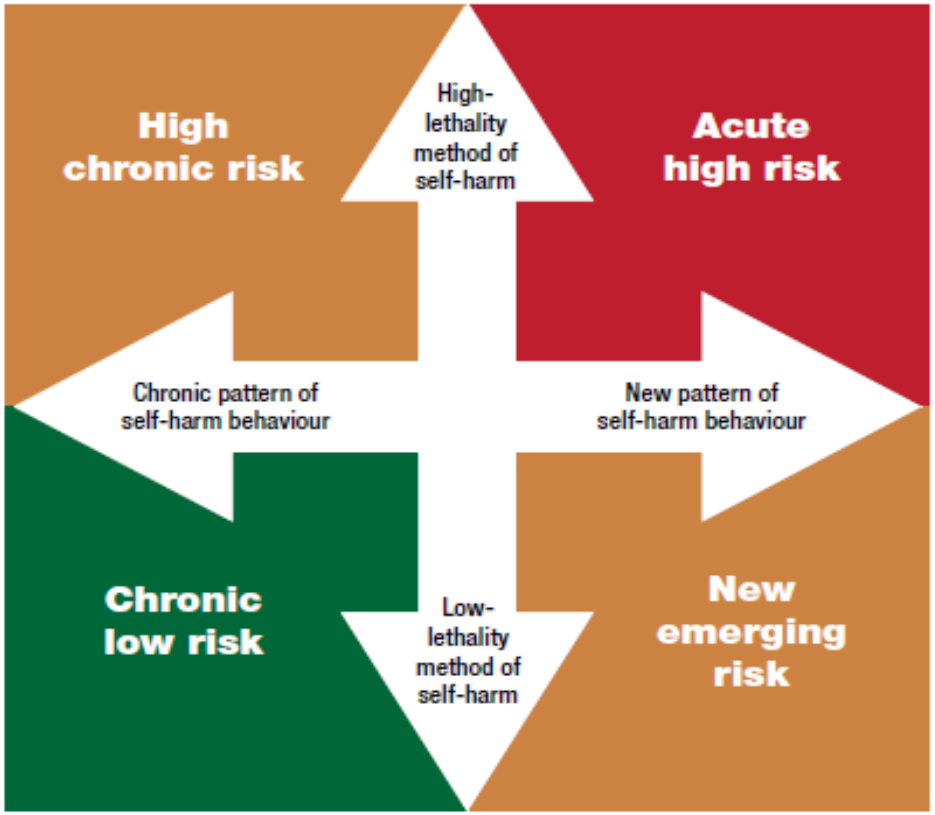
NHMRC guidelines for BPD - 2012

Figure 8.1 Estimating probable level of suicide risk based on self-harm behaviour



Adapted from Spectrum (personality disorder service for Victoria: www.spectrumbpd.com.au)

Figure 8.1 is a guide to estimating the probable level of risk in a person with BPD who self-harms, by considering the pattern and lethal potential of self-harm. However, risk may change suddenly or be difficult to predict based solely on the signs and symptoms available to the clinician. Frequent review, a trusting therapeutic relationship and helping the person to build a strong support network are necessary to help keep the person safe.

Eastern Health

BPD-specific risk factors

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- Sexual abuse
- Changes in the usual **pattern** or type of self-harm
- Co-occurring mental illness, depression, ASPD, SUD
- Repeated high lethal attempts in a short period of time
- Severe abandonment emotional dynamics
- Emergence of psychotic states
- Severe regression
- High levels of impulsivity (Soloff et al 2005, Soloff et al 2000, Livesley 2003, Brodsky 1997)
- Chronic severe emptiness- ***identitylessness***
- Severe self-loathing
- Chronic and high levels of hopelessness (Soloff et al 2000)
- Prolonged dissociation
- Access to medications
- Age: 25 - 64 years
- Gender: ? male

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Suicide

Suicide risk can increase when BPD patients believe that they are *unlovable*

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Suicide in BPD is preventable

- **Spectrum: Death by suicide- 12 out of 4000 patients in treatment**
- **Spectrum follow-up data: 2% death rate**
- **My own data- one suicide in 25 years**
- **BPD experts: Low suicide rate**
- **Zanarini follow up study- 4.6% at 16 years**
- ***When people with BPD are treated suicide risk goes away***

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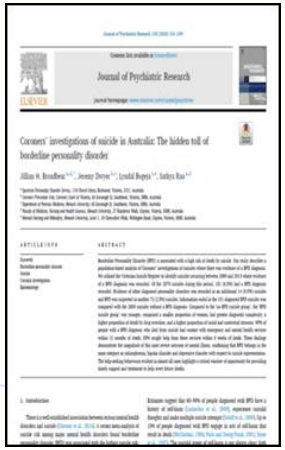
BPD Suicides in Victoria (2009-2013)

(Spectrum – Vic Coroners Court study 2018)

- **99%** of them had passed through public mental health services in the preceding 1 year
- **88%** made contact in the last 6 weeks
- **18-64 years of age- 95% of all BPD suicides**


Journal of Psychiatric Research

Coroners' investigations of suicide in Australia: The hidden toll of borderline personality disorder

Take home message

Any reasonable treatment provided by reasonable clinicians in a reasonable manner may be beneficial to persons with BPD.

- Zanarini

Take home message

"As long as you don't judge, as long as you try to validate the valid and as long as you can tolerate emotions (yours and theirs) and teach them skills to improve their quality of life, you can contribute to their recovery journey"

Give it a go!

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Thank you

Setting up the treatment contract

- After an adequate assessment you have decided to take up June for psychotherapy (weekly). How would you go about setting up a treatment contract?

- Video 2 of June with her therapist
- Role Play 2_Spectrum
- https://youtu.be/I4MvWZcQxHQ

Second therapy appointment

- Video 3 of June with her therapist
-
- Role Play 3_Spectrum
- https://youtu.be/g8_7jm2MkRY

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Sixth therapy appointment

- Video 4 of June with her therapist

- Role Play 4_Spectrum
- https://youtu.be/Ohf_SFVnajQ

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Seventh therapy appointment

- Video 1 of June with her therapist

- Role Play 1_ Spectrum
- https://youtu.be/-oAi0k5BTRI