



THESE ARE JUST SOME OF THE THINGS I'M FEELING RIGHT NOW  
 THESE ARE JUST SOME OF THE THOUGHTS IN MY HEAD...

**B** **O** **R** **D** **E** **R** **L** **I** **N** **E**

FRANTIC CHAOS  
 SELF HARM  
 ABANDONED  
 BROKEN  
 ALONE  
 SUICIDE  
 LACK AND WHO AM I?!  
 UNSTABLE  
 ONE  
 D  
 AID  
 OST  
 TRAPPED  
 SORRY  
 XHAUSTED  
 EMPTY

IF YOU'RE LIVING WITH ANY OF THESE FEELINGS TOO, YOU'RE A HERO IN MY EYES.

# **Borderline Personality Disorder: The Science and the Art of Treatment**

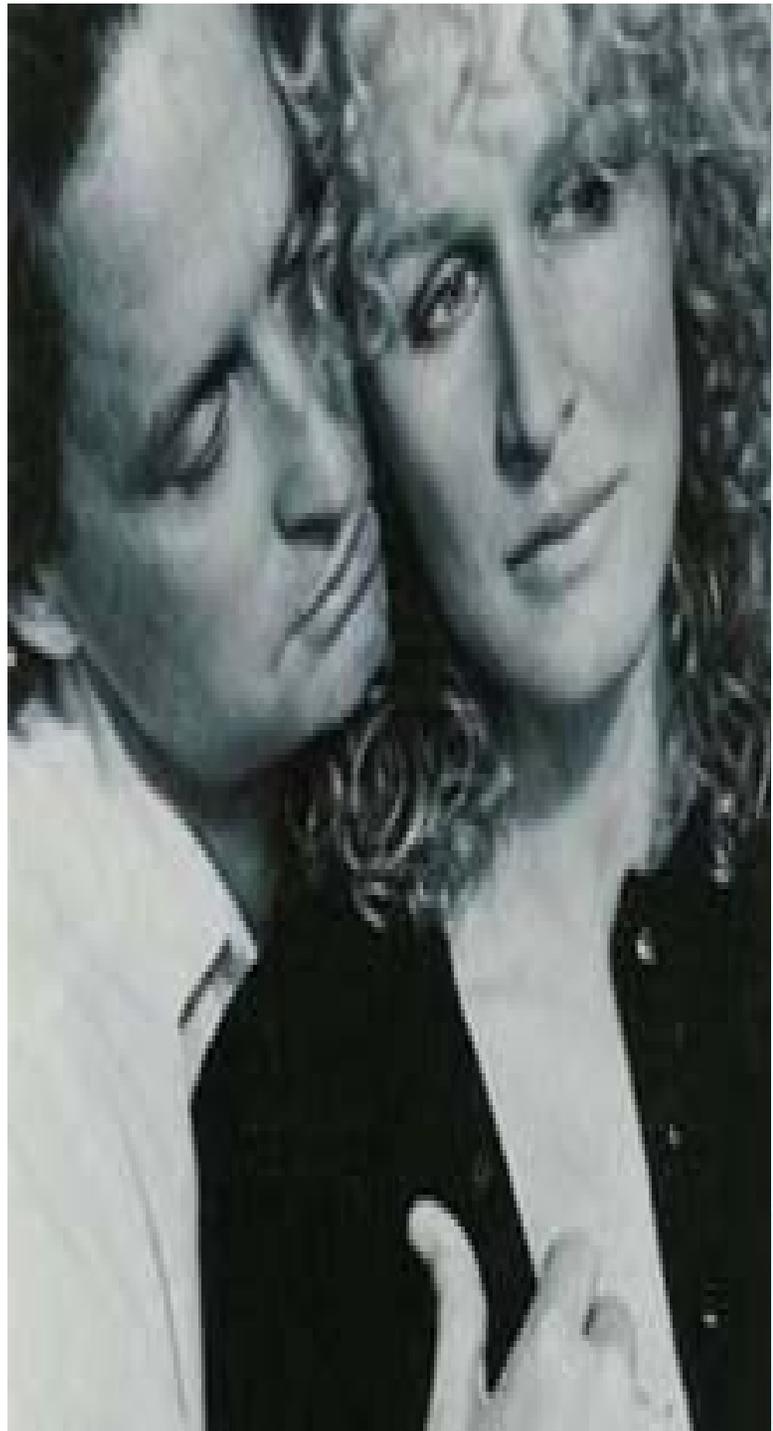
**Carmen V. Pinto, M.D.  
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# Previous Labels

- Initially described as being on the border between neurosis and psychosis
- Ambulatory Schizophrenia
- As-if Personality
- Pseudo-Neurotic Schizophrenia
- Psychotic Character Disorder
- Borderline Personality Disorder
- Emotionally Unstable Personality Disorder (ICD-10)



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you're not crazy.

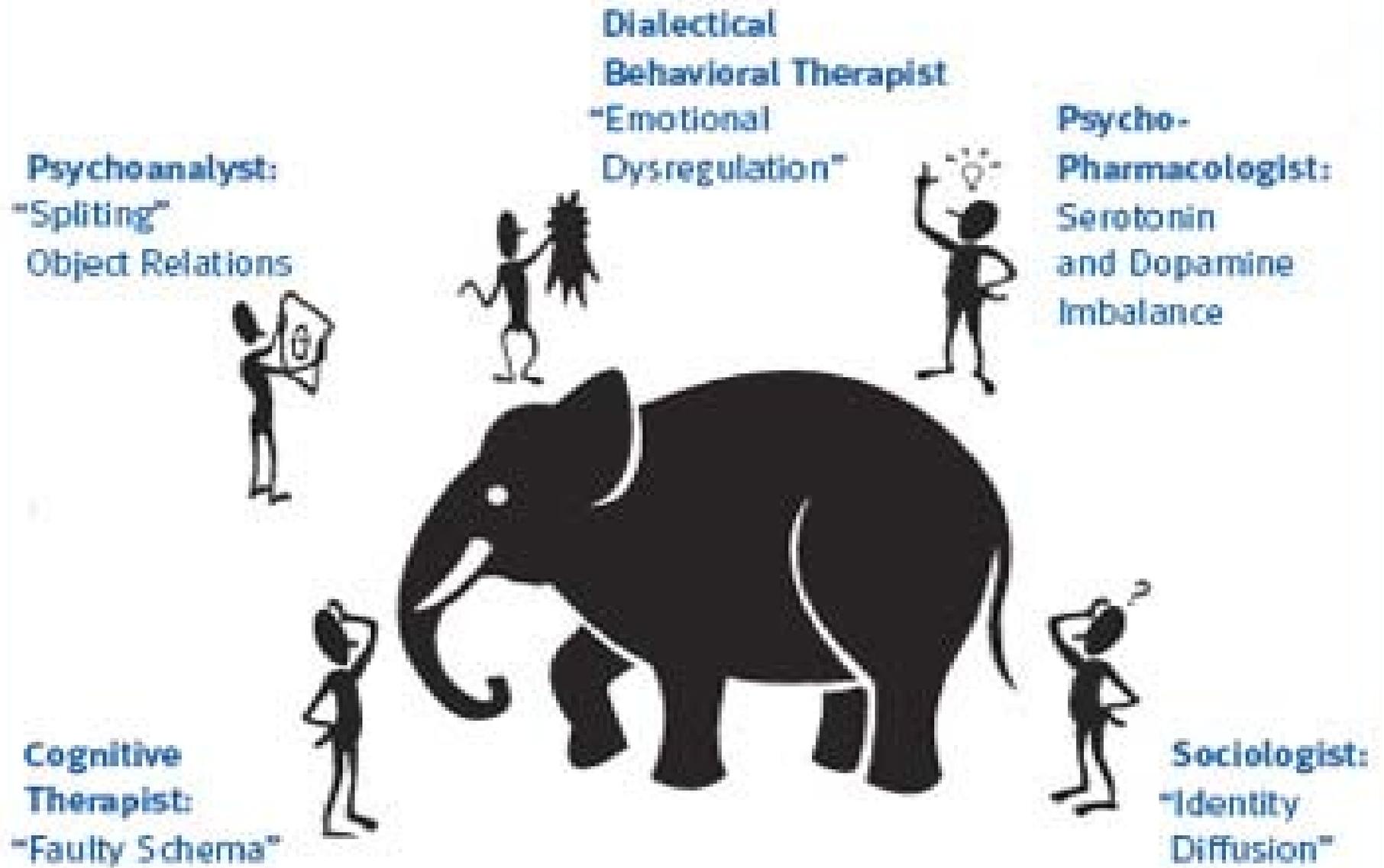
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# GIRL, INTERRUPTED®

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## How Various Disciplines See Borderline Personality Disorder



# General Personality Disorder

## Criteria DSM5

A) An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture. Manifested in two or more of the following areas:

1. Cognition: ways of perceiving and interpreting self, people, and events.
2. Affectivity: the range, intensity, lability and appropriateness of emotional response.
3. Interpersonal functioning.
4. Impulse control.

B) The enduring pattern is inflexible and pervasive across a broad range of personal and social situations.

C) The enduring pattern leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning.

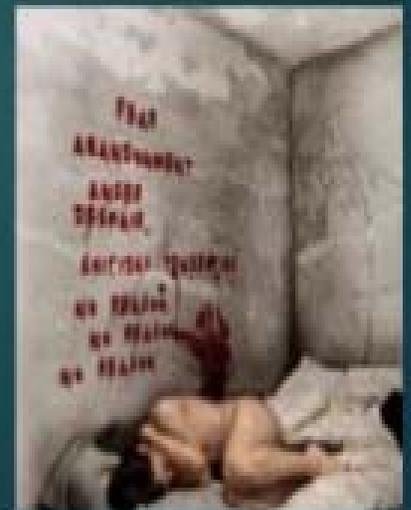
# General Personality Disorder

## Criteria DSM5 (cont.)

D) The pattern is stable and of long duration, and its onset can be traced back at least to adolescence or early adulthood.

E) The enduring pattern is not better explained as a manifestation or consequence of another mental disorder.

F) The enduring pattern is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., head trauma).



# Borderline Personality Disorder

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## Diagnostic Criteria

**301.83 (F60.3)**

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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.
-

# DSM-IV-TR Personality Disorders

(A “dimensionally-flavored” categorical system)

## A. Cluster A (odd/eccentric)

1. Paranoid
2. Schizoid
3. Schizotypal

## B. Cluster B (dramatic/emotional/impulsive)

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

## C. Cluster C (anxious/fearful)

1. Avoidant
2. Dependent
3. Obsessive-Compulsive

## D. Personality Disorder Not Otherwise Specified

# DSM-5 Field Trials: Test – Retest Reliability

Data from 11 Academic Centers

<b>Pooled Test – Retest Reliability</b>		
DSM-5 Diagnosis	Intraclass Kappa	Interpretation
Major Neurocognitive Disorder	0.78	Very Good
Posttraumatic Stress Disorder	0.67	Very Good
Bipolar I Disorder	0.56	Good
<b>Borderline Personality Disorder</b>	<b>0.54</b>	<b>Good</b>
Schizophrenia	0.50	Good
Mild Neurocognitive Disorder	0.48	Good
Major Depressive Disorder	0.28	Questionable
Mixed Anxiety-Depressive Disorder	0.004	Unacceptable

- Regier et al., *AJP*, 2012

# Barriers to Diagnosis

- “Mood Swings” = Bipolar; **rapid (daily) mood swings that are in reaction to the environment** are more likely Borderline PD
- Typical teen-age behavior; **suicide attempts and self mutilation, fear of abandonment** more likely Borderline PD
- Substance Use – often comorbid, **careful hx**
- Can't DX personality disorders until 18; **PDs begin early in adulthood**
- **Pejorative, Stigma, Use DX criteria, honesty**

# Borderline Personality Disorder

## “I RAISED A PAIN”

**I** Identity disturbance

**R** Relationships are unstable

**A**bandonment frantically avoided (whether real or imagined)

**I**mpulsivity

**S**uicidal gestures (threats, self-mutilation, etc.)

**E**mpiness

**D**issociative symptoms

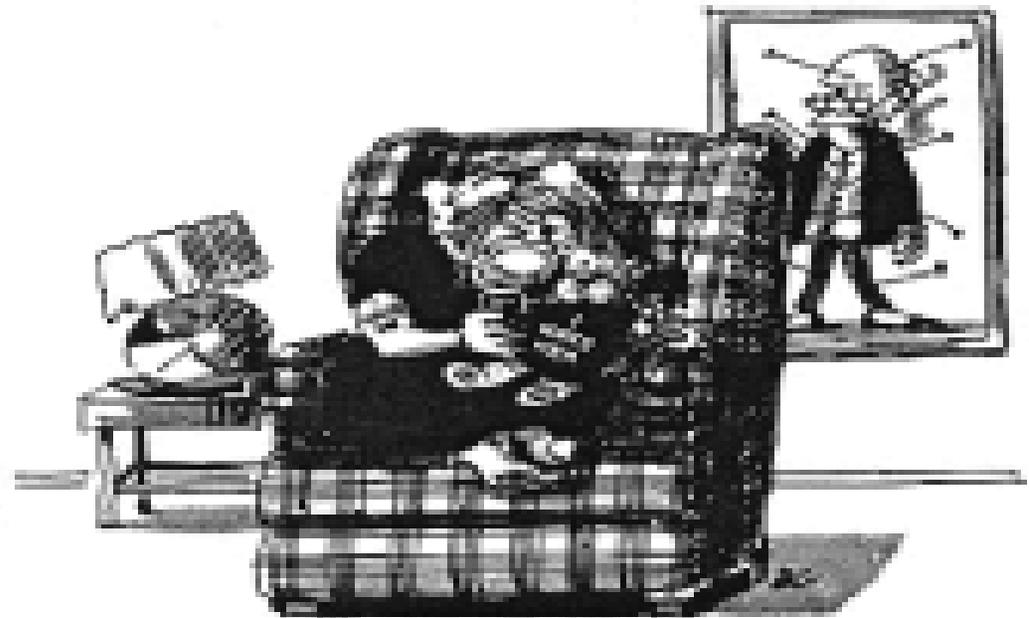
**A**ffective instability

**P**aranoid ideation (stress-related and transient)

**A**nger is poorly controlled

**I**dealization followed by devaluation

**N**egativistic (undermine themselves with self-defeating behavior)



# Epidemiology

- \* 1-2% of the general population
- \* **Twice as common in women**
- \* High co morbidity with mood, anxiety, substance use disorders and PTSD
- \* **6% in primary care setting**
- \* **10% of psychiatric outpatient setting**
- \* **19% chronic non-cancer pain (CNCP)**
- \* **50-80% report self-injurious behavior**
- \* **75% will attempt suicide**
- \* **10% will complete suicide**

# High Lifetime Comorbidity

- Any Mood Disorder 96%
  - MDD 75%
- Any Anxiety Dis 88%
  - Panic 41%
  - PTSD 51%
- SUD 60%
- Eating Disorder 17%

● The MOST difficult pts have mood/psychotic disorder, an anxiety disorder, a substance use disorder and a personality disorder

# Genetic variation in personality traits explains genetic overlap between borderline personality features and substance use disorders

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## Abstract

**Aims**—To examine the genetic overlap between borderline personality features (BPF) and substance use disorders (SUDs) and the extent to which variation in personality traits contributes to this covariance.

**Design**—Genetic structural equation modelling was used to partition the variance in and covariance between personality traits, BPF, and SUDs into additive genetic, shared, and individual-specific environmental factors.

**Setting**—All participants were registered with the Australian Twin Registry.

**Participants**—A total of 3,127 Australian adult twins participated in the study.

**Measurements**—Diagnoses of DSM-IV alcohol and cannabis abuse/dependence (AAD; CAD), and nicotine dependence (ND) were derived via computer-assisted telephone interview. BPF and five-factor model personality traits were derived via self-report questionnaires.

**Findings**—Genetic factors were responsible for 49% (95%CI: 42%–55%) of the variance in BPF, 38–42% (95%CI range: 32%–49%) for personality traits and 47% (95%CI: 17%–77%), 54% (95%CI: 43%–64%), and 78% (67%–86%) for ND, AAD and CAD, respectively. Genetic and individual-specific environmental correlations between BPF and SUDs ranged from .33–.56 (95%CI range: .19–.74) and .19–.32 (95%CI range: .06–.43), respectively. Overall, there was substantial support for genetic influences that were specific to AAD, ND and CAD (31%–69%).

# Bio-Psycho-Social Model

- **Bio**logical – Genetics, Brain structures and Functions, Neurotransmitters, Medications, Medical Procedures
- **Psycho**logical – How one perceives and thinks about him/herself, others and the world.
- **Social** – Environmental influences: relationships, diseases, injuries, events etc. (developmentally sensitive)

## Borderline personality disorder is a heritable brain disease

The prevailing view among many psychiatrists and mental health professionals is that borderline personality disorder (BPD) is a “psychological” condition. BPD often is conceptualized as a behavioral consequence of childhood trauma; treatment approaches have emphasized intensive psychotherapeutic modalities, less so biologic interventions. You might not be aware that a large body of research over the past decade provides strong evidence that BPD is a neurobiological illness—a finding that would drastically alter how the disorder should be conceptualized and managed.

### Neuropathology underpins the personality disorder

Foremost, BPD must be regarded as a serious, disabling brain disorder, not simply an aberration of personality. In DSM-5, symptoms of BPD are listed as: feelings of abandonment; unstable and intense interpersonal relationships; unstable sense of self; impulsivity; suicidal or self-mutilating behavior; affective instability (dysphoria, irritability, anxiety); chronic feelings of emptiness; intense anger episodes; and transient paranoid or dissociative symptoms. Clearly, these clusters of psychopathological and behavioral symptoms reflect a pervasive brain disorder associated with abnormal neurobiology and neural circuitry that might, at times, stubbornly defy therapeutic intervention.

No wonder that 42 published studies report that, compared with healthy

controls, people who have BPD display extensive cortical and subcortical abnormalities in brain *structure* and *function*.<sup>1</sup> These anomalous patterns have been detected across all 4 available neuroimaging techniques.

**Magnetic resonance imaging.** MRI studies have revealed the following abnormalities in BPD:

- hypoplasia of the hippocampus, caudate, and dorsolateral prefrontal cortex
- variations in the CA1 region of the hippocampus and subiculum
- smaller-than-normal orbitofrontal cortex (by 24%, compared with healthy controls) and the mid-temporal and left cingulate gyri (by 26%)
- larger-than-normal volume of the right inferior parietal cortex and the right parahippocampal gyrus
- loss of gray matter in the frontal, temporal, and parietal cortices
- an enlarged third cerebral ventricle
- in women, reduced size of the medial temporal lobe and amygdala
- in men, a decreased concentration of gray matter in the anterior cingulate
- reversal of normal right-greater-than-left asymmetry of the orbitofrontal cortex gray matter, reflecting loss of gray matter on the right side
- a lower concentration of gray matter in the rostral/subgenual anterior cingulate cortex
- a smaller frontal lobe.

continued



Henry A. Nasrallah, MD  
Editor-in-Chief

BPD must be regarded as a serious, disabling brain disorder, not simply an aberration of personality and behavior

To comment on this editorial or other topics of interest, visit [www.facebook.com/CurrentPsychiatry](http://www.facebook.com/CurrentPsychiatry), or go to [CurrentPsychiatry.com](http://CurrentPsychiatry.com) and click on the “Contact Us” link.

# Data Supporting Biological Factors in Borderline PD

**Genetic** – poly-genetic: polymorphisms in serotonin, MAO, COMT, BDNF genes etc.

**Chemical** – decreased activity of serotonin, oxytocin, increased MAO activity etc.

**Structural** – decreased PFC, hippocampus and nucleus accumbens volume; increased amygdala volume etc.

**Functional** – increased threat detection; decreased reward system, decreased joy and cognitive processing etc.

**Epidemiological** – twin studies, family studies etc.

**Table 1**  
Genetic association studies on borderline personality disorder (BPD).

Gene name	Gene symbol	Authors	Polymorphism investigated	Sample investigated	Type of analysis
Tryptophan hydroxylase 1	<i>TPH1</i>	Zaboli et al. (2006) <sup>a</sup>	rs4537731, rs684302, rs211105, rs1800532, rs1799913, rs7933505 ACGCCG haplotype	95 women with BPD/98 women controls	Case–control
Tryptophan hydroxylase 1	<i>TPH1</i>	Maurex et al. (2009)		42 women with BPD, 30 controls	ANOVA
Tryptophan hydroxylase 1	<i>TPH1</i>	Wilson et al. (2009) <sup>a</sup>	rs1800532	100 cases/101 controls	Case–control
Tryptophan hydroxylase 1	<i>TPH1</i>	Wilson et al. (2012) <sup>a</sup>	rs4537731, rs1800532	98 cases/300 depressed patients	Logistic regression
Tryptophan hydroxylase 1	<i>TPH1</i>	Ni et al. (2009) <sup>a</sup>	rs7130929, rs1800532	113 cases/113 controls	Case–control
Tryptophan hydroxylase 2	<i>TPH2</i>	Perez–Rodriguez et al. (2010) <sup>d</sup>	rs2171363, rs1386491, rs6582078, rs1352250 (“risk” haplotype)	109 cases/103 controls	Case–control
Tryptophan hydroxylase 2	<i>TPH2</i>	Ni et al. (2009)	rs4570625, rs11178997, rs10784941, rs1843809, rs1386494, rs2171363, rs1487280, rs1872824	113 cases/113 controls	Case–control
Serotonin receptor 1A	<i>HTR1A</i>	Ni et al. (2009)	rs6295, rs878567, rs749099, rs1364043	113 cases/113 controls	Case–control
Serotonin receptor 1A	<i>HTR1A</i>	Zetsche et al. (2008)	rs6295 G/C	25 women with BPD, 25 matched controls	Case–control coupling genetic/MRI
Serotonin receptor 1B	<i>HTR1B</i>	Ni et al. (2009) <sup>b</sup>	rs1213371, rs11568817, rs130058, rs6296, rs6297	113 cases/113 controls	Case–control
Serotonin receptor 1B	<i>HTR1B</i>	Tadić et al. (2009a,b,c) <sup>b</sup>	rs11568817, rs130058, rs6296, rs6297	161 cases/156 controls	Case–control
Serotonin	<i>HTR1D</i>	Ni et al. (2009)	rs674386, rs6300	113 cases/113 controls	Case–control

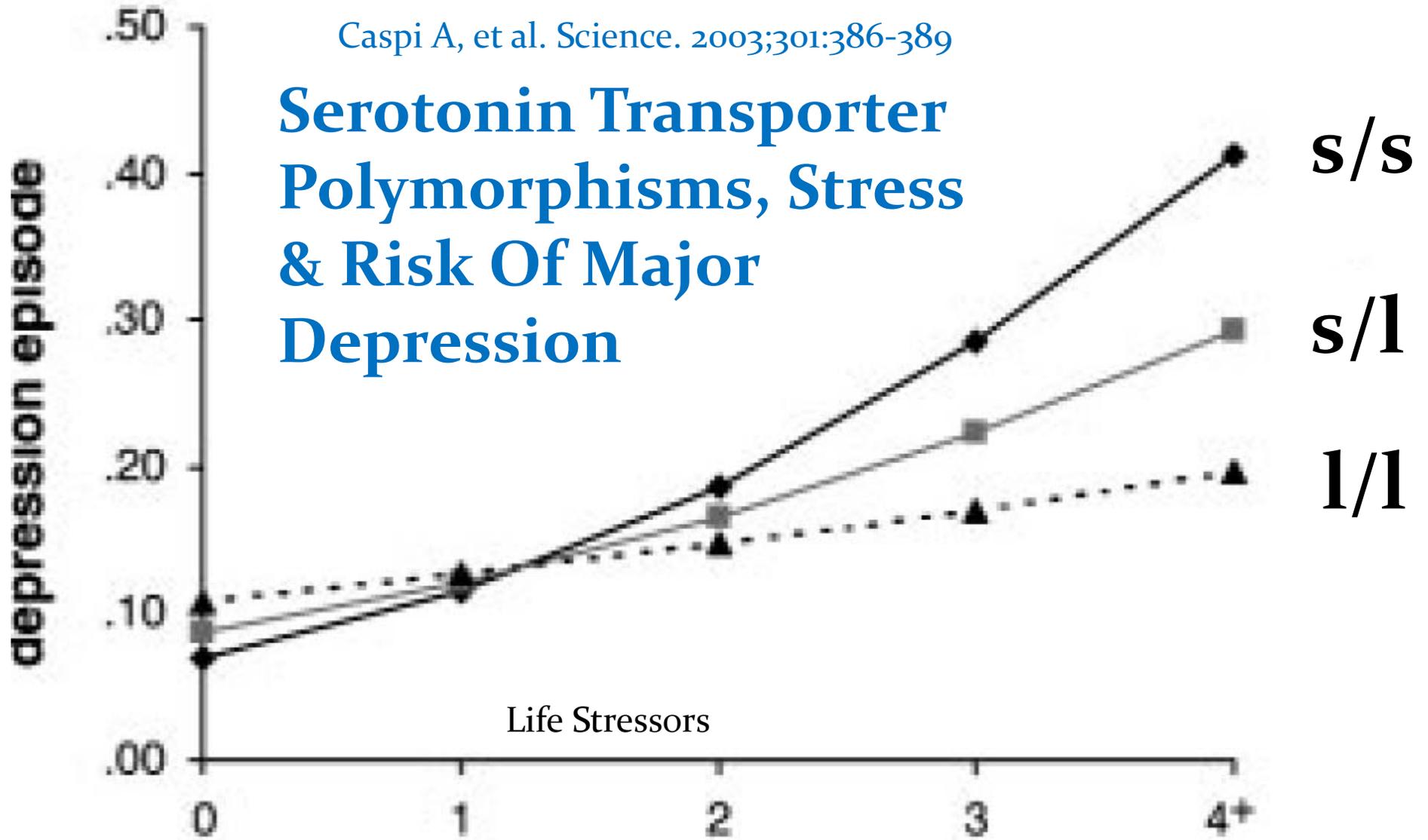
**Table 3**  
Gene–environment studies in borderline personality disorder (BPD).

Polymorphism investigated	Authors	Sample investigated	Type of analysis	Findings
<i>SLC6A4</i> (5-HTTLPR)	Wagner et al. (2009)	159 patients with BPD	ANOVA, regression analyses	SLEs <sup>a</sup> were associated with a decrease in impulsivity in SS/SL carriers.
<i>COMT</i> (rs4680)	Wagner et al. (2010c)	159 patients with BPD	Linear regression analyses	No modulating effects
<i>BDNF</i> (rs6265)	Wagner et al. (2010b)	159 patients with BPD	ANOVA, regression analyses	Childhood sexual abuse decreased impulsive aggression in <i>BDNF</i> Val/Val carriers
<i>COMT</i> (rs4680)	Wagner et al. (2010a)	112 women with BPD	ANOVA, regression analyses	In <i>COMT</i> Val158Val carriers, childhood sexual abuse and the number of SLE were associated with decreased impulsive aggression
<i>TPH1</i> (rs4537731 and rs1800532)	Wilson et al. (2012)	398 patients with mood disorders assessed for BPD and sexual abuse	Logistic regression	Significant interaction effects between genotype and abuse history

<sup>a</sup> SLE: serious life events.

Caspi A, et al. Science. 2003;301:386-389

# Serotonin Transporter Polymorphisms, Stress & Risk Of Major Depression



# Testing the Fear Response in People with Genetic Serotonin Transporter (SERT) Polymorphism

●	SS	ll
●		Subliminal
●		'Mean Faces'
●	amygdala	amygdala
●	over-activation	activation
●	Delayed Recovery	Recovery
●	Anxiety/Depression	No Sxs

Stahl's  
Essential  
Psychophar  
macology.  
3<sup>rd</sup> Ed.  
2008.

How Does this Relate to non-verbal Reactions seen in patients?



## Association between methylation of the glucocorticoid receptor gene, childhood maltreatment, and clinical severity in borderline personality disorder



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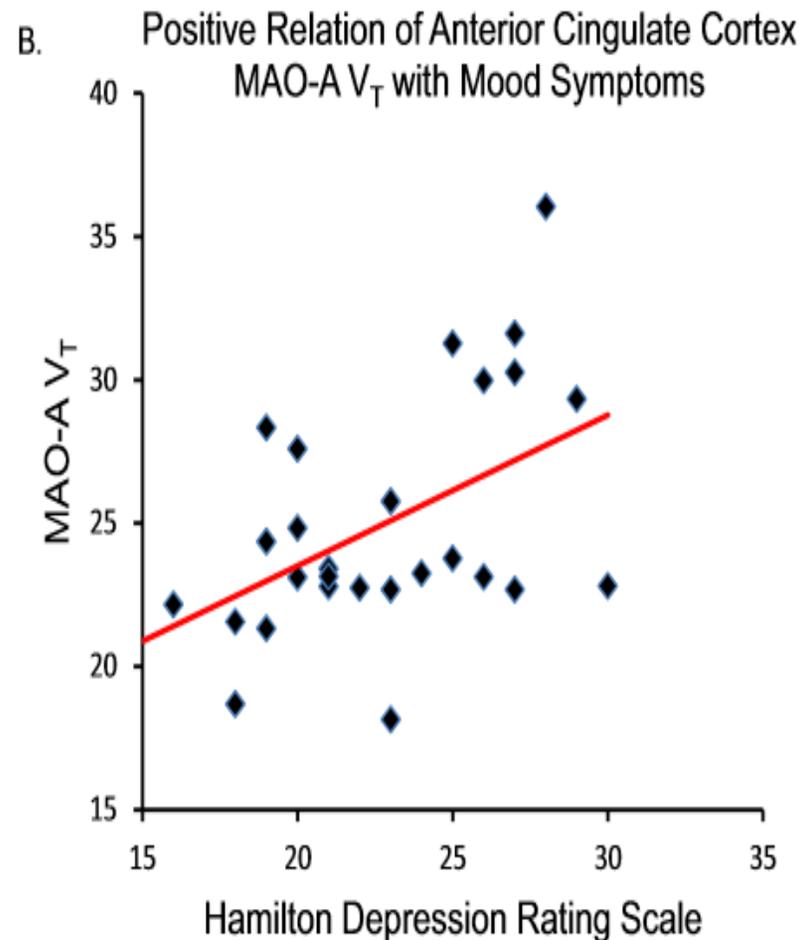
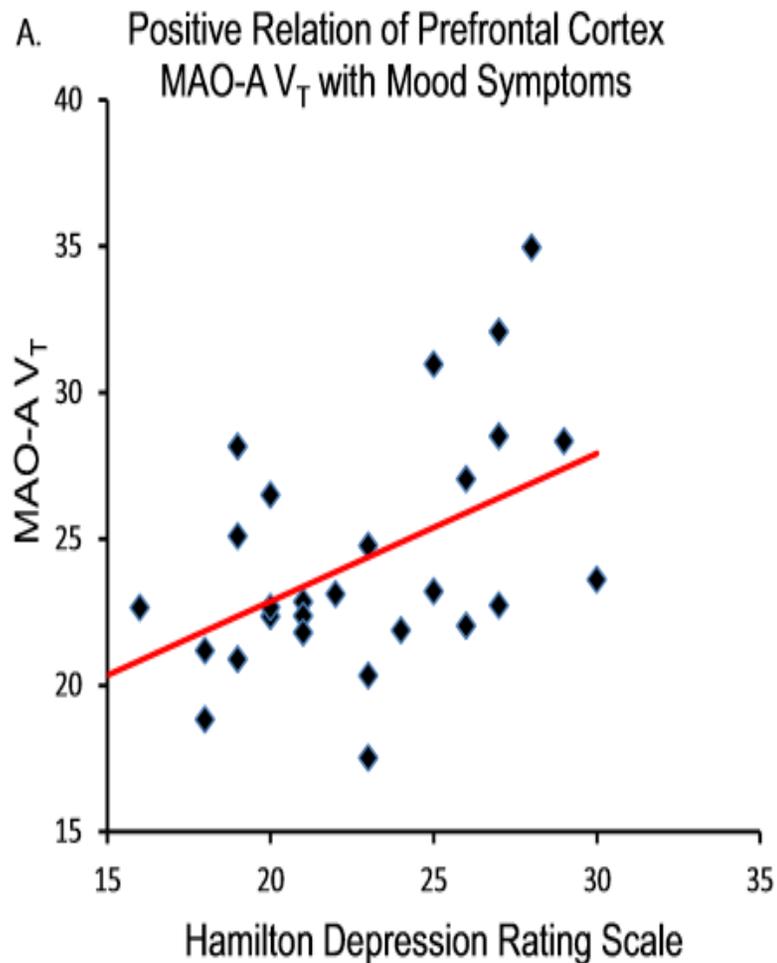
Methylation

Glucocorticoid receptor gene

Childhood trauma

### ABSTRACT

The hypothalamus-pituitary-adrenal axis (HPA) is essential in the regulation of stress responses. Increased methylation of the promoter region of the glucocorticoid receptor gene (*NR3C1*) has been described both in subjects with history of childhood trauma and in patients with Borderline Personality Disorder (BPD). However, no data on the possible association between a higher methylation of this gene and clinical severity is available. The aim of this study was to evaluate the association between *NR3C1* methylation status, the history of childhood trauma, and current clinical severity in subjects with BPD. A sample of 281 subjects with BPD (diagnosed by SCID-II and DIB-R semi-structured diagnostic interviews) was recruited. Clinical variables included previous hospitalizations, self-injurious behavior, and self-reported history of childhood trauma. DNA was extracted from peripheral blood. The results indicated a significant positive correlation between *NR3C1* methylation status and childhood maltreatment (specifically physical abuse). In addition, a positive correlation between methylation status and clinical severity (DIB-R total score and hospitalizations) was observed. These findings suggest that *NR3C1* methylation in subjects with BPD may be associated not only with childhood trauma but also with clinical severity, adding new evidence to the involvement of gene-environment interactions in this disorder.

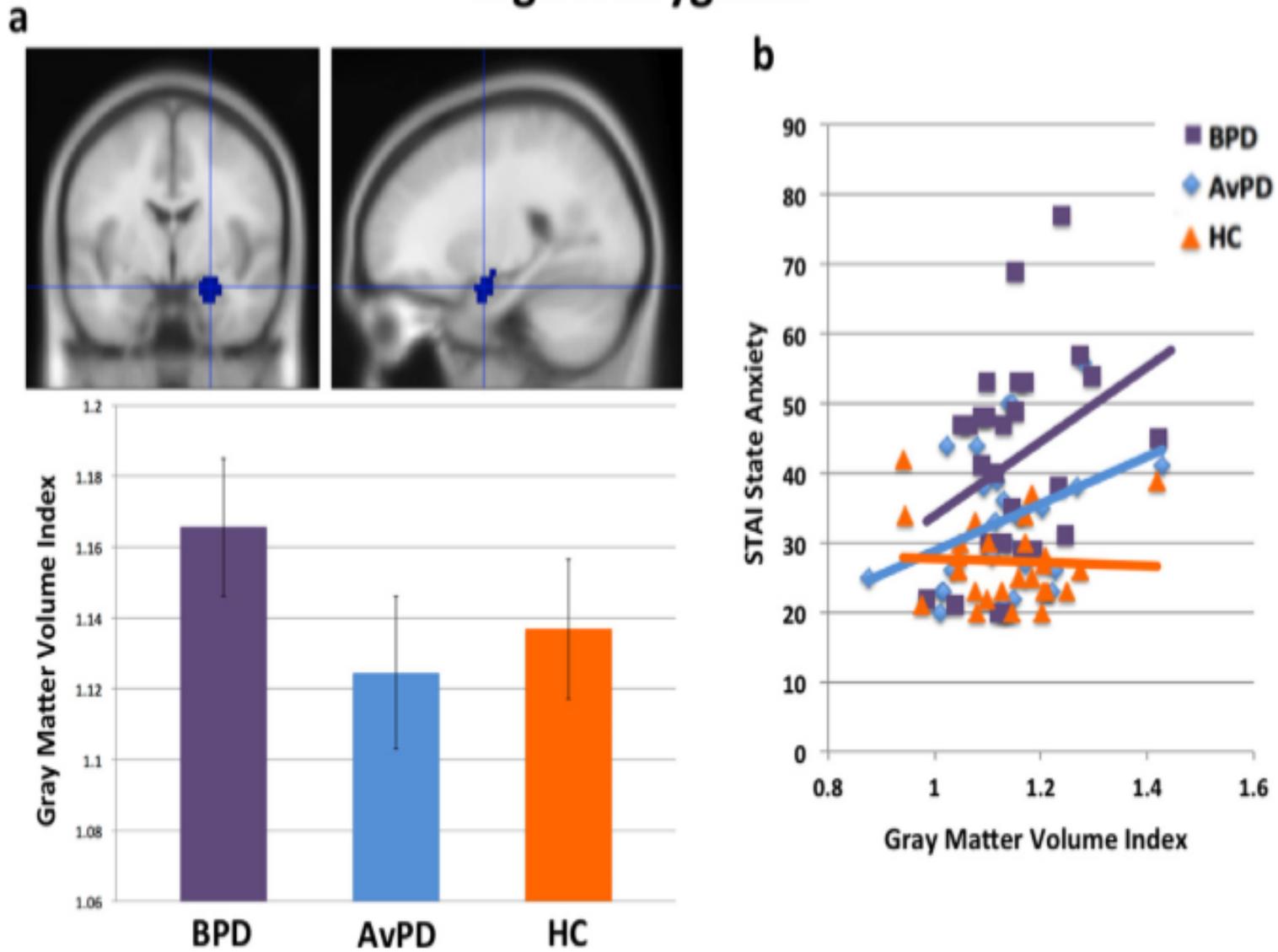


**Figure 2.** (A) Prefrontal cortex monoamine oxidase-A total distribution volume (MAO-A  $V_T$ ) is positively correlated with Hamilton Depression Rating Scale score (Pearson's  $r = .52$ ,  $p = .005$ , two-tailed). (B) Anterior cingulate cortex MAO-A  $V_T$  is positively correlated with Hamilton Depression Rating Scale score (Pearson's  $r = .53$ ,  $p = .004$ , two-tailed).

Kolla, N. et al. elevated MAO-A in BPD associated with mood, impulsivity and suicidality severity

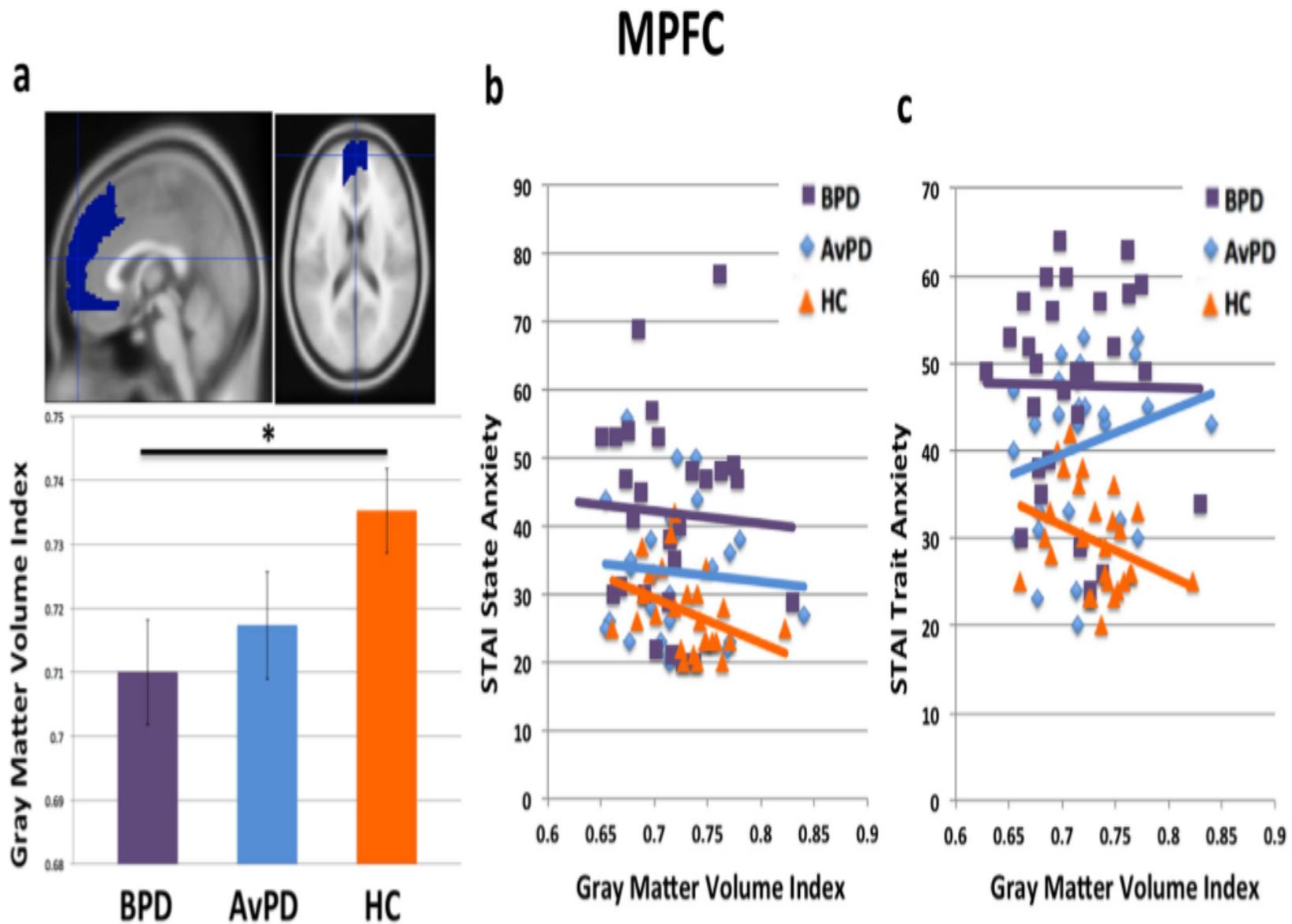
Biological Psychiatry ■■■, 2015; ■:■■■-■■■ [www.sobp.org/journal](http://www.sobp.org/journal) 5

# Right Amygdala



**Fig. 1.** (a) Right amygdala volumes by group and (b) gray matter volume correlations with STAI-State scores.

Denny, B.T. et al., *J. of Affective Disorders*; 200 (2016), 266-274



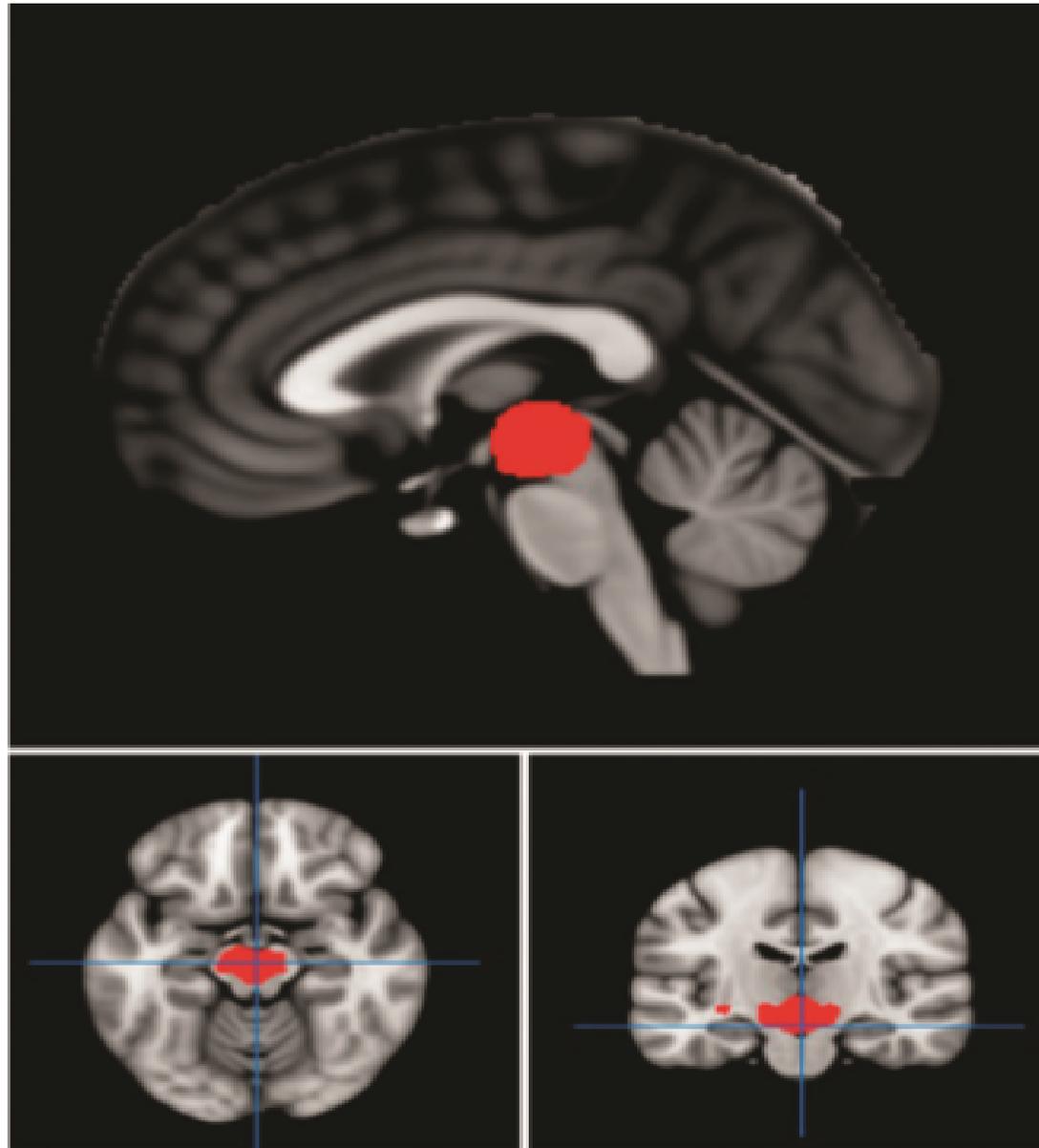
**Fig. 3.** (a) MPFC volumes by group. (b) Gray matter volume correlations with STAI-State scores. (c) Gray matter volume correlations with STAI-Trait scores. \* reflects a significant pair-wise difference,  $p < 0.05$ , two-tailed.)

Denny, B.T. et al., *J. of Affective Disorders*; 200 (2016), 266-274

## Childhood trauma and midbrain activation in BPD

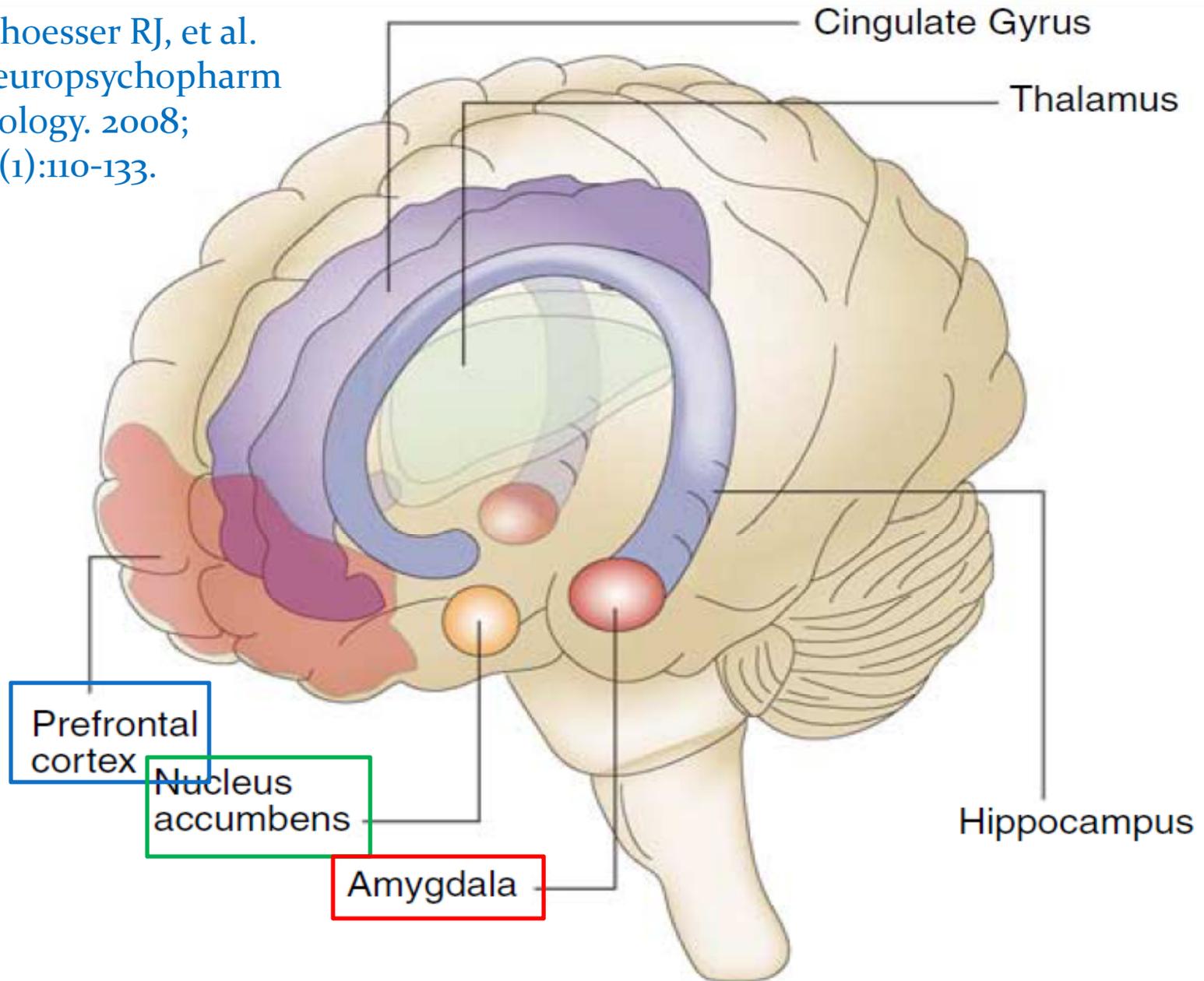
K. Nicol, et al.

Translational Psychiatry (2015),



**Figure 3.** Region of activation in midbrain, which correlated significantly with childhood physical abuse, as assessed by the CTQ, in those with borderline personality disorder. Red areas show activation meeting threshold  $P < 0.005$  within a midbrain/ventral striatum mask, superimposed on the mean T1 image. CTQ, childhood trauma questionnaire.

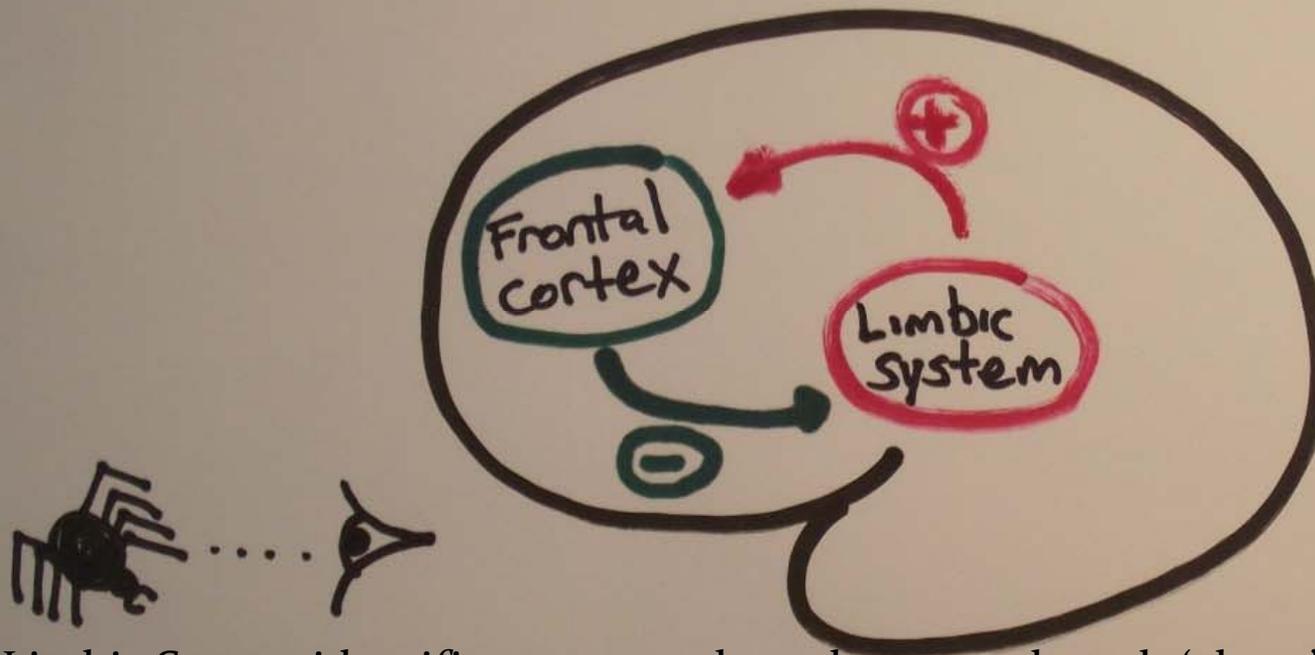
Schoesser RJ, et al.  
Neuropsychopharmacology. 2008;  
33(1):110-133.



**Figure 2** Neuroanatomical regions implicated in affective processes. Neuroimaging studies, observations on patients with selective CNS lesions,

# Basic Brain Stress response

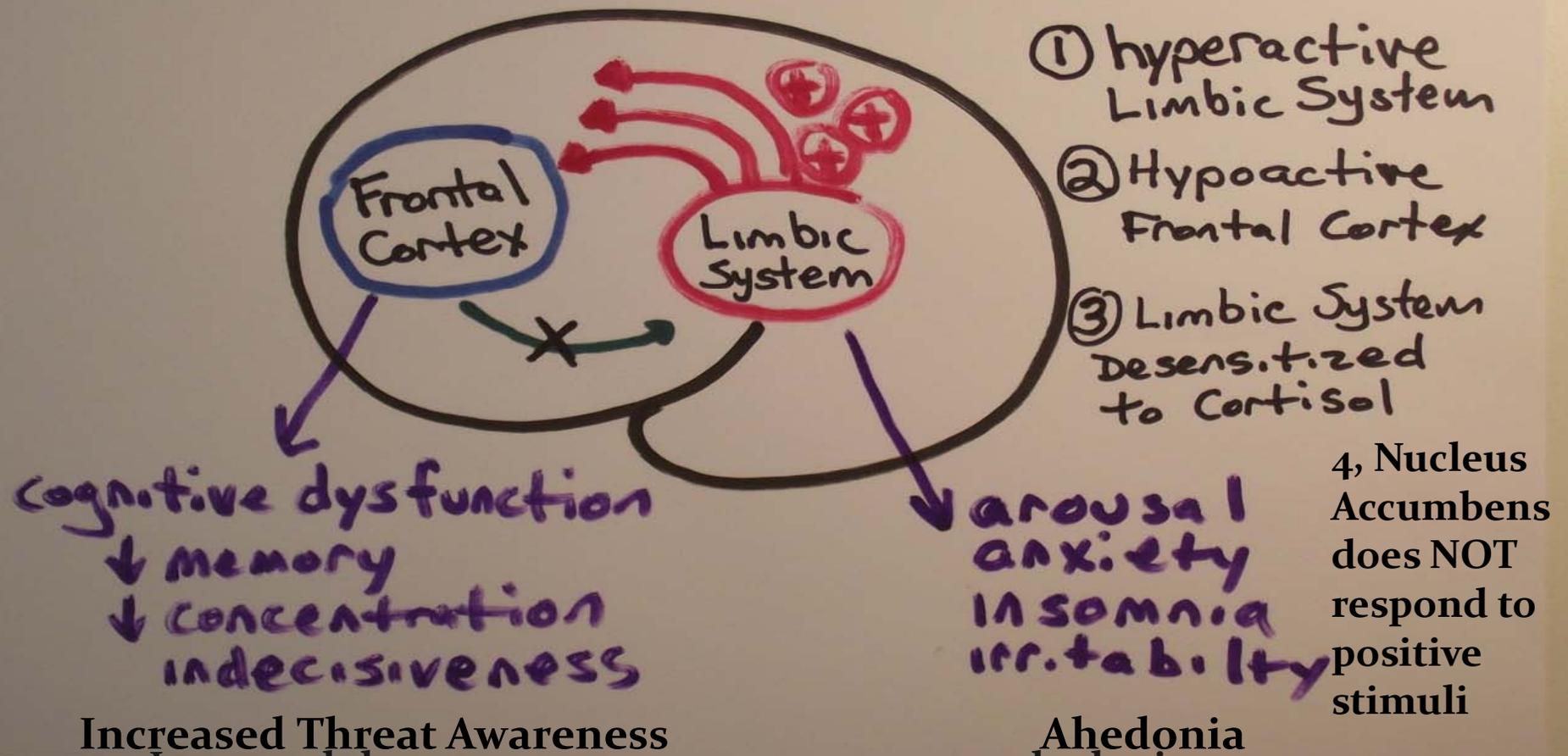
## Cortical-Limbic Function



Limbic System identifies or remembers threats and sends 'alarm' (excitatory) signals to cortex. Cortex processes signal and applies context. Cortex then provides feedback to Limbic system, inhibitory feedback will turn off Limbic 'alarm' signal.

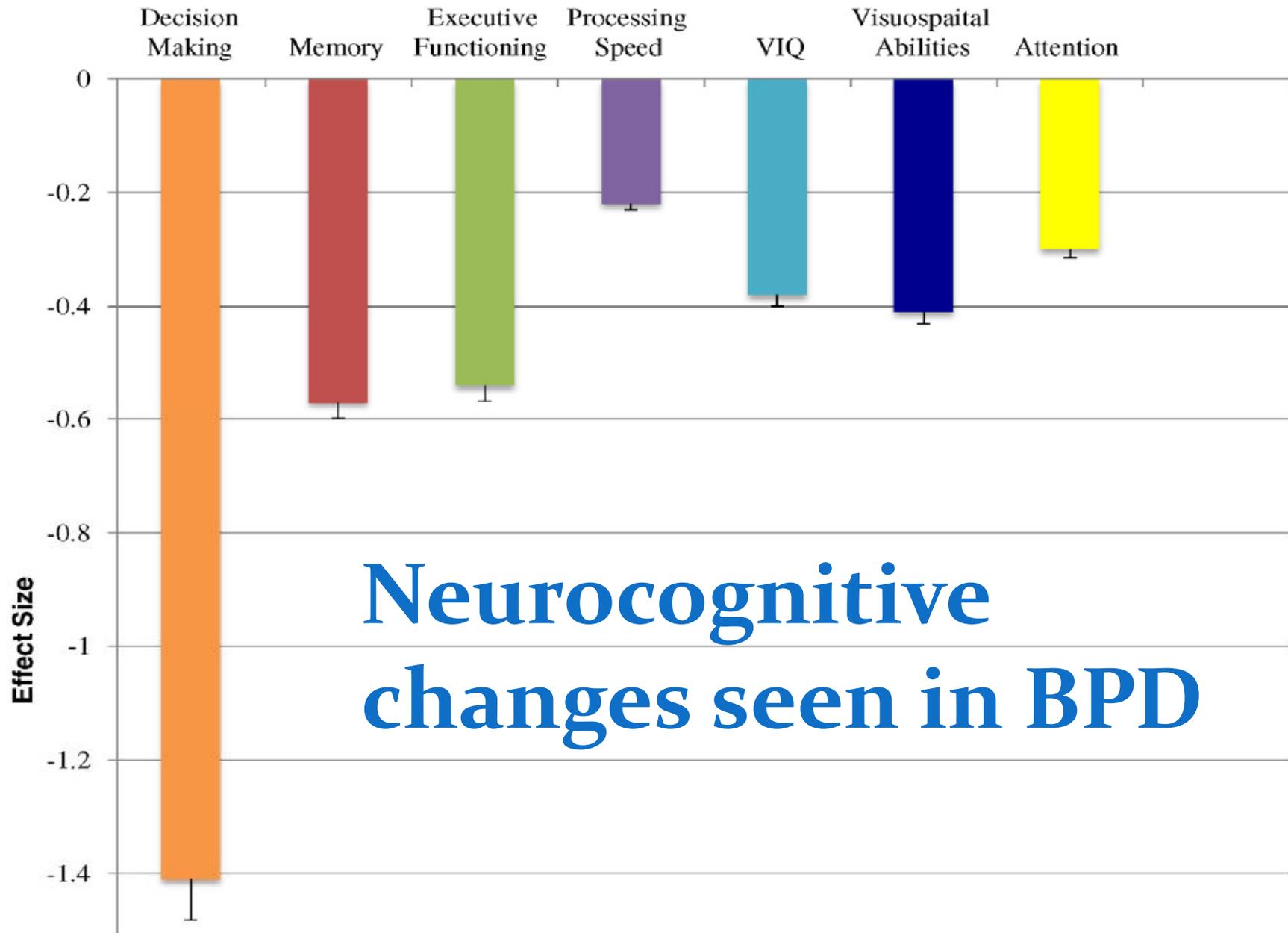
There is Bi-directional communication of the stress response with the body by the sympathetic nervous system, the endocrine system & the immune system

# Cortical-Limbic Dysfunction



**'Runaway' Alarm system can result from 1) genetically sensitive amygdala, 2) genetically hypo functioning Frontal Cortex (FC), 3) both, 4) extreme stress to a 'normal' FC/Amygdala system (PTSD)**

## Neurocognitive Domains

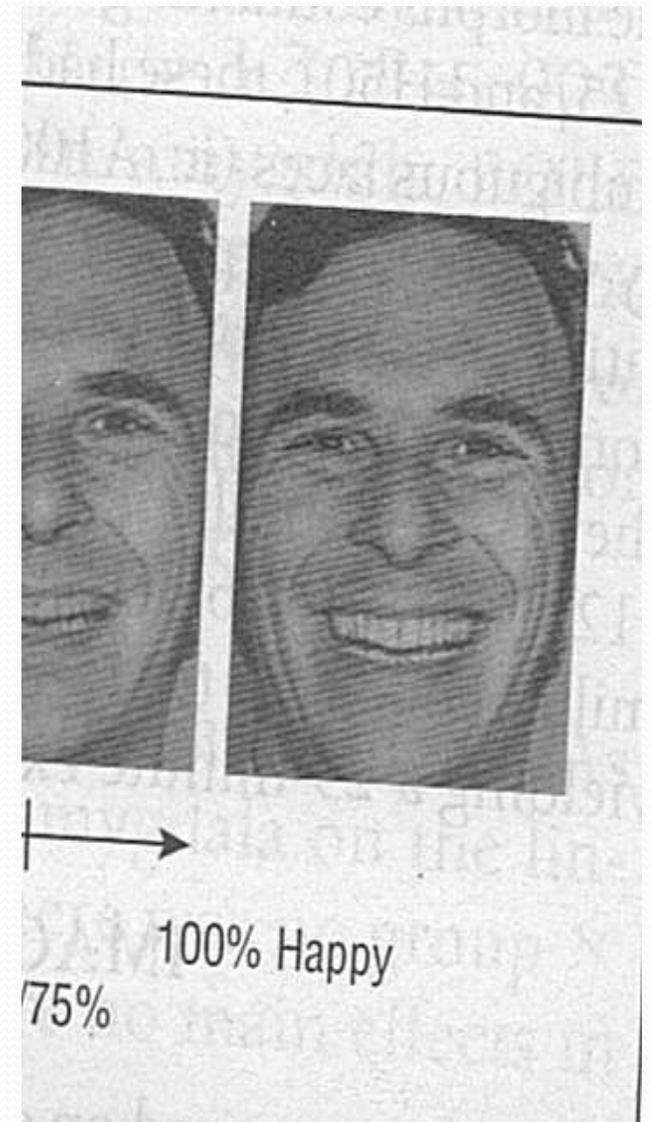


# The Environmental Factors that lead to BPD are type and time sensitive

- **Critical developmental periods** when people are young is when personality and personality disorders develop
- Often the trauma is type II, which is ongoing and personal like childhood sexual abuse (**92% of people with BPD report neglect and sexual or physical abuse**)

- **Often the environment is invalidating**
  - **(The child is not believed or blamed)**
- **Often the message is so contradictory** (spoken: I love you, actions: I hurt and rape you) **that the child learns not to trust words** and navigates the world based on nonverbal cues and perceptions based on a **brain wired for negative expectations**

# Facial Emotional Valence



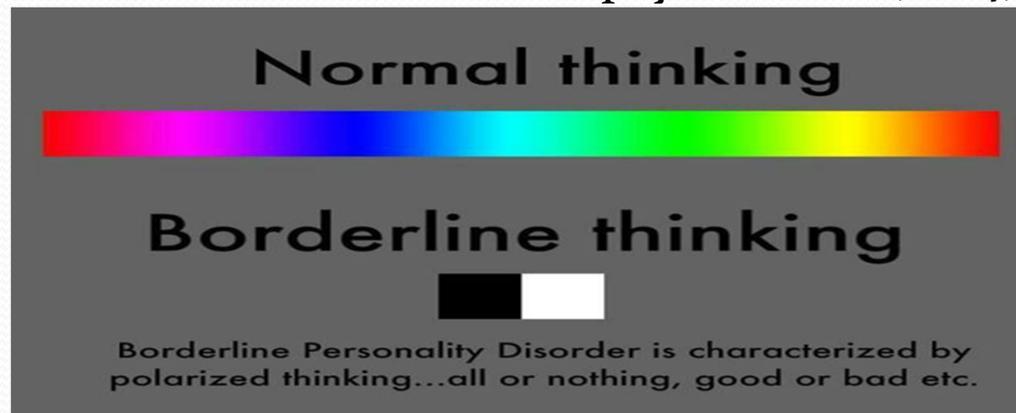
# Facial Emotion Processing in Borderline Personality Disorder: A Systematic Review and Meta-Analysis

Accurately identified full emotional intensity facial images

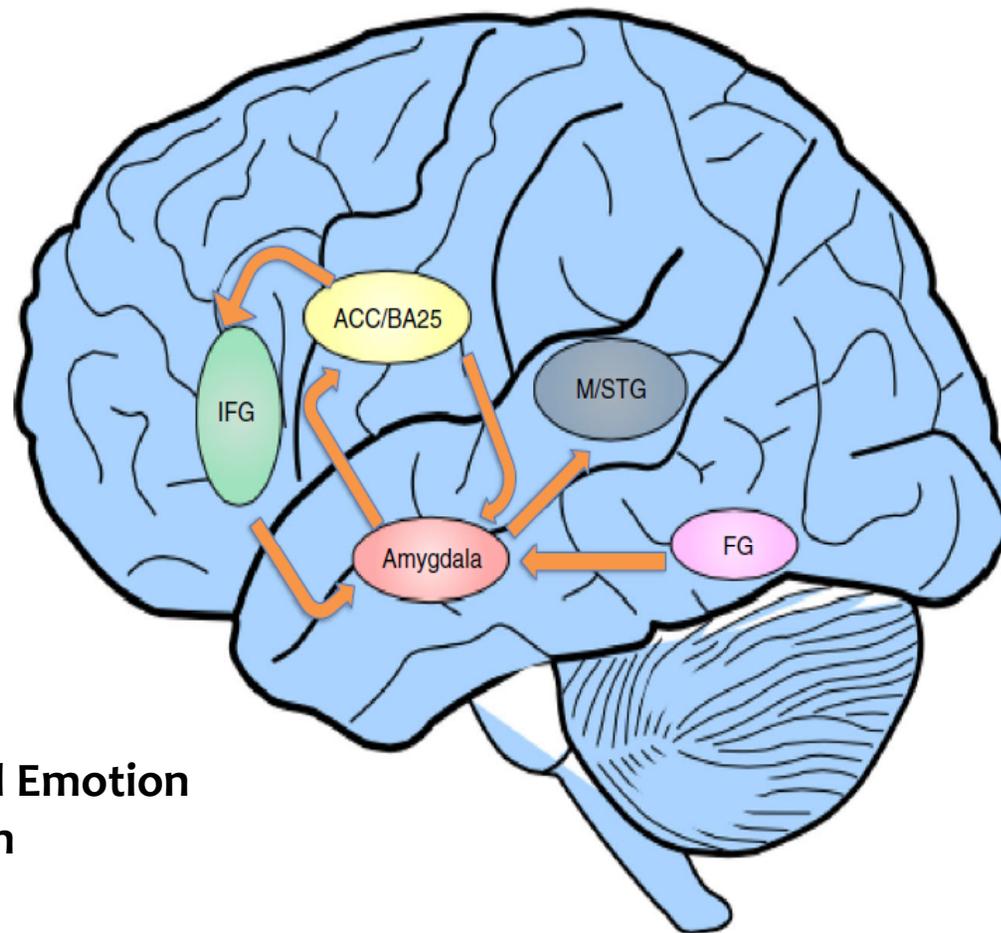
Tendency for patients with BPD to inaccurately recognize or misclassify ambiguous facial expressions as negative

Increased amygdala activation in Facial Emotional Processing (FEP) in persons with BPD

Mitchell, A. E. et al, Neuropsychol Rev (2014) 24:166–184



“Splitting”  
“All or Nothing”  
Thinking



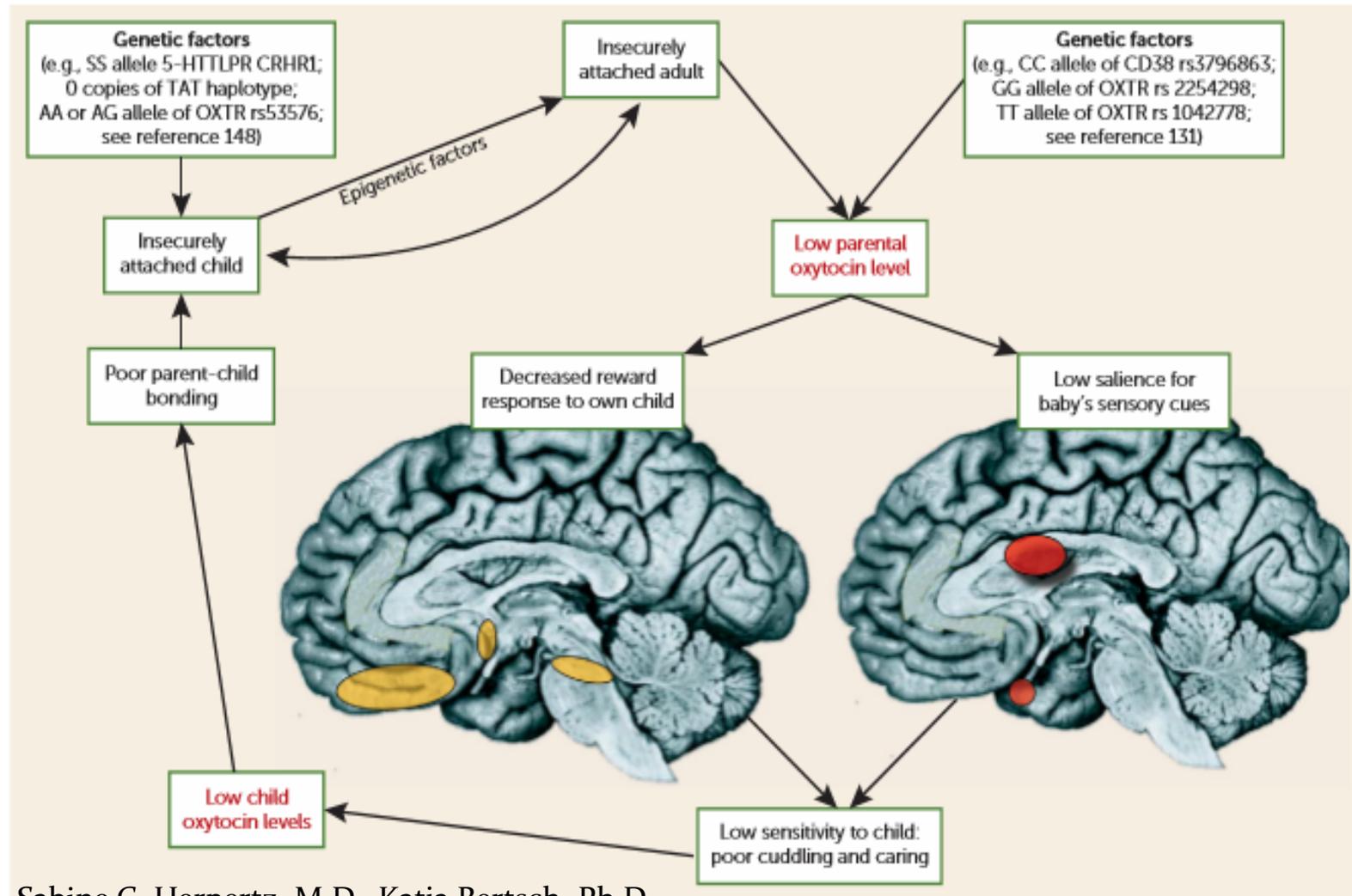
## FER = Facial Emotion Recognition

Fig. 3 A hypothetical model of brain circuitry in FER in borderline personality disorder. The Fusiform Gyrus (FG) has object, including facial specific processing functions that are fed from the visual cortex. Disordered structural and functional connectivity between modulatory regions such as the ACC/BA25 (Anterior Cingulate Cortex/Broadmann Area 25) or prefrontal cortex (IFG-Inferior Frontal Gyrus) and the amygdala may contribute to disordered functional feedback that normally

modulates amygdala processing of environmental stimuli. Abnormal amygdala processing of emotional cues contributes to disordered hippocampal and lateral temporal activity (M/STG Middle/Superior Temporal Gyrus), that is expressed as heightened sensitivity to emotional stimuli and psychotic like experiences in the context of the resulting heightened arousal (Lis et al. 2007; Meyer-Lindenberg and Weinberger 2006; O'Neill and Frodl 2012)

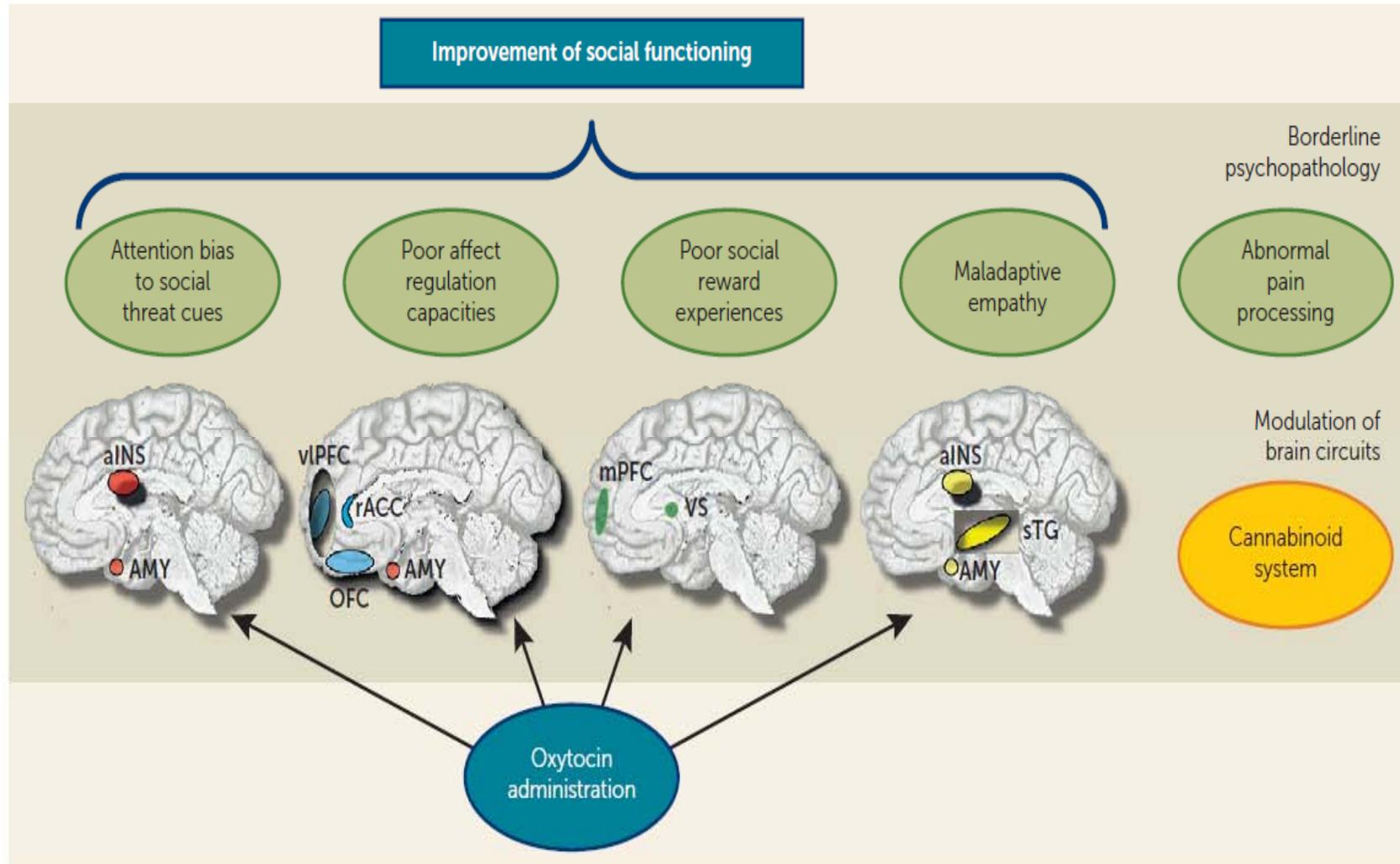
ROLE OF OXYTOCIN IN THE PATHOPHYSIOLOGY OF BORDERLINE PERSONALITY DISORDER

**FIGURE 1. Model of the Implications of a Dysfunctional Oxytocin System on Parent-Child Bonding**



Sabine C. Herpertz, M.D., Katja Bertsch, Ph.D.  
AmJPsychiatry2015;172:840–851;doi:10.1176/appi.ajp.2015.15020216

FIGURE 2. Model of the Significance of the Oxytocin System on Biobehavioral Mechanisms Underlying Borderline Psychopathology<sup>a</sup>



<sup>a</sup> aINS=anterior insula; AMY=amygdala; vIPFC=ventrolateral prefrontal cortex; rACC=rostral anterior cingulate cortex; OFC=orbitofrontal cortex; mPFC=medial prefrontal cortex; sTG= superior temporal gyrus; VS=ventral striatum.

# Summary BPD Hypothesis

<u>Genetic polymorphisms</u>	<u>Chemical</u>	<u>Functional Activity</u>	<u>Behavioral</u>
SERT	↓ 5-HT	↑ Amygdala	↑ Threat
TPH <sub>1</sub>	↓ oxytocin	↓ Nucleus Accumbens	↓ Joy Reward
BDNF	↓ BDNF	↓ PFC	Indecisiveness
COMT	↑ Cortisol MAO		impulsivity

# Core Concept

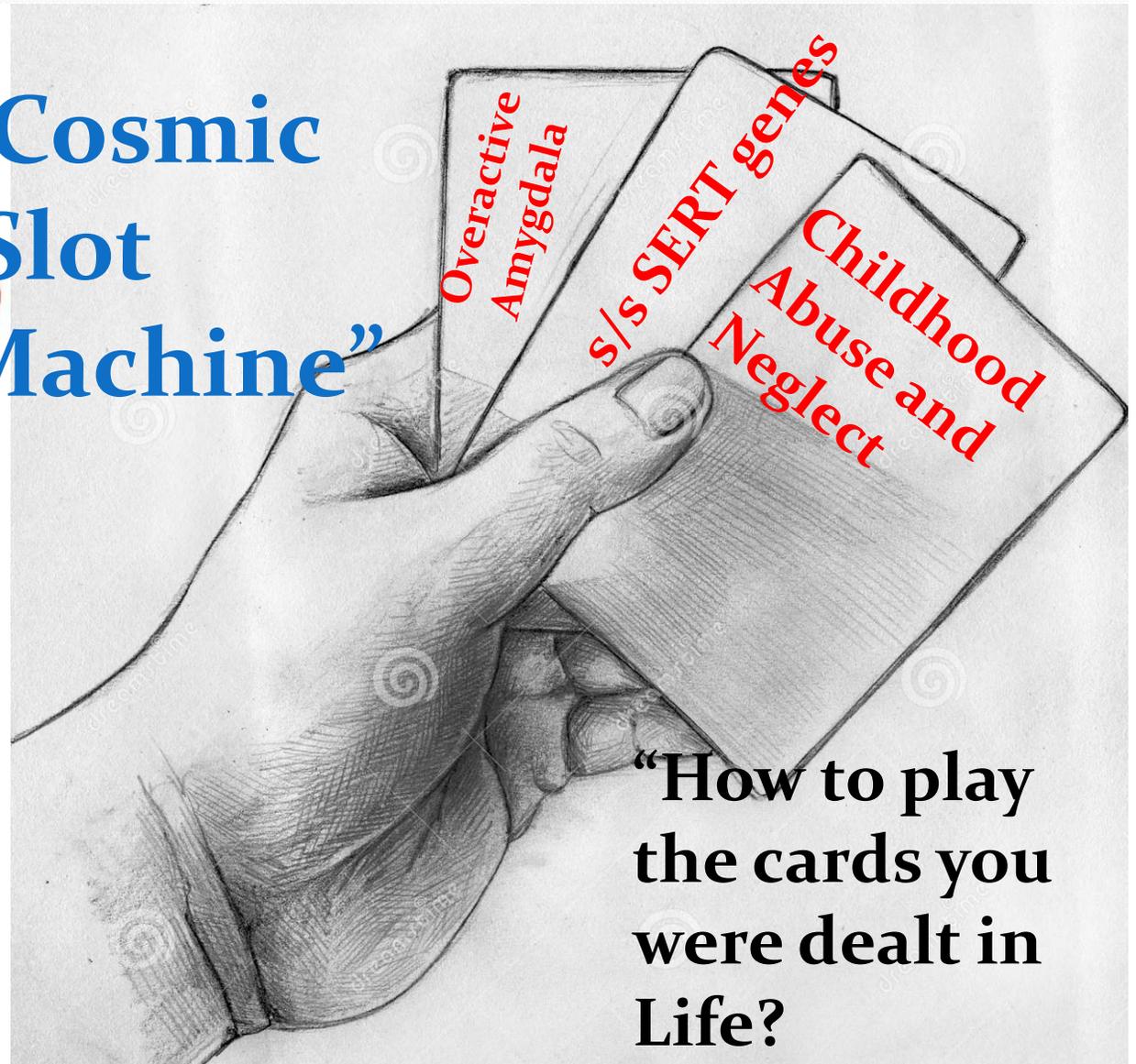
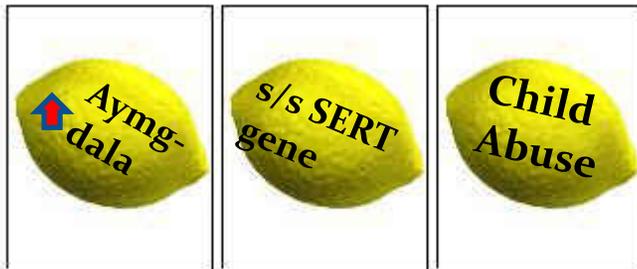
- Genetic risks (Stress Tolerance) and environmental interactions (Stress) shape our brains, which shape how we see the world, which shapes our lives
- Early life trauma can lead to a hyperactive amygdala, which causes increased threat detection (fear & worry)
- Early life trauma shuts down nucleus accumbens, which decreases pleasure and reward (anhedonia)
- 
- The person then may present with a pessimistic view of self and world; living life as though the 'glass was always half empty.' Not by choice but by biology.

# “Trauma Sucks and is not Fair, but it is what it is”

C. Pinto, M.D.

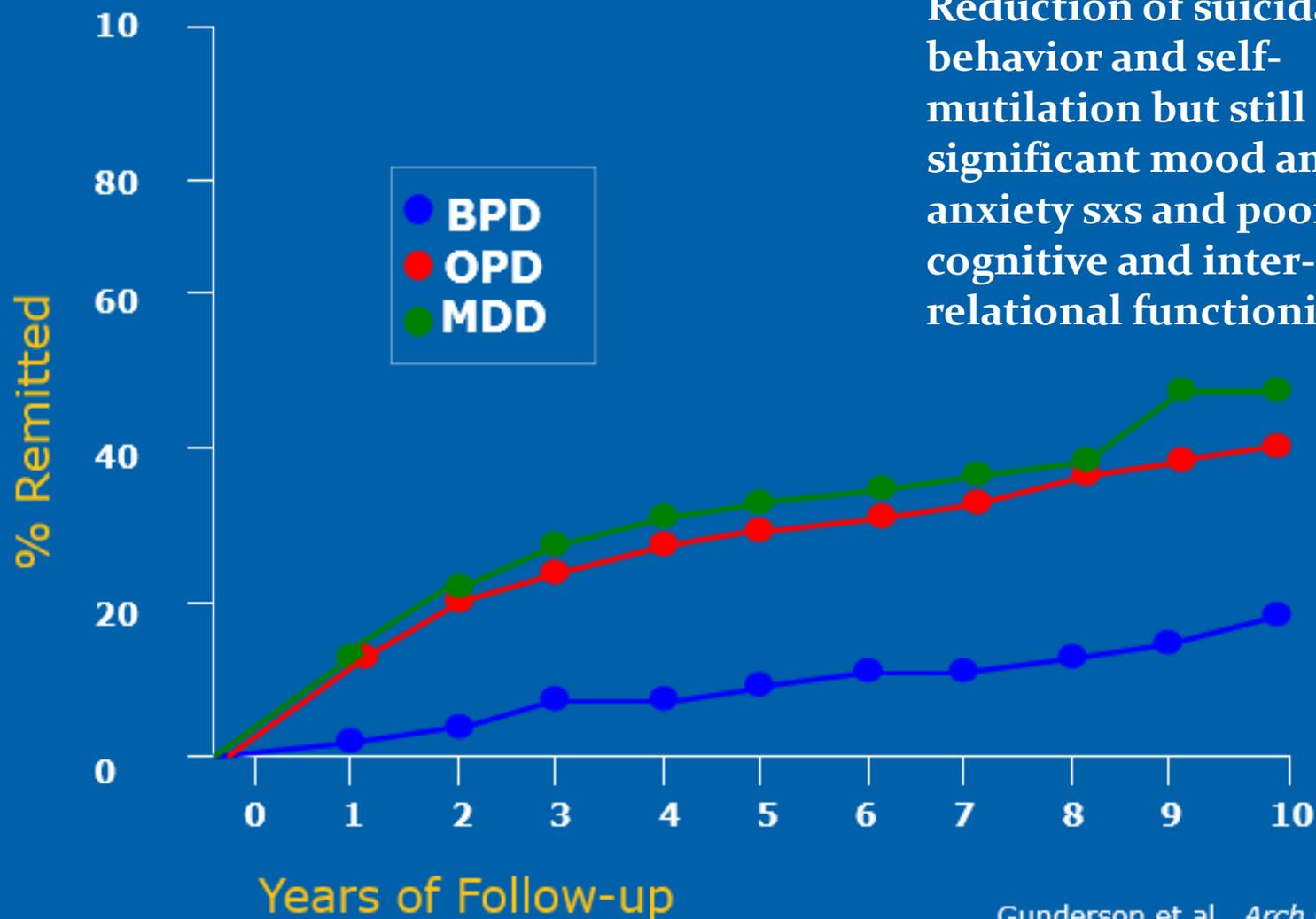


“Cosmic  
Slot  
Machine”

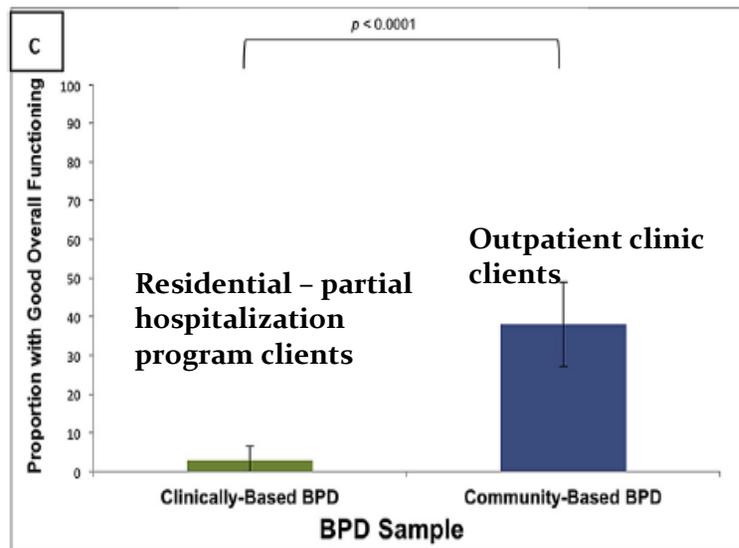
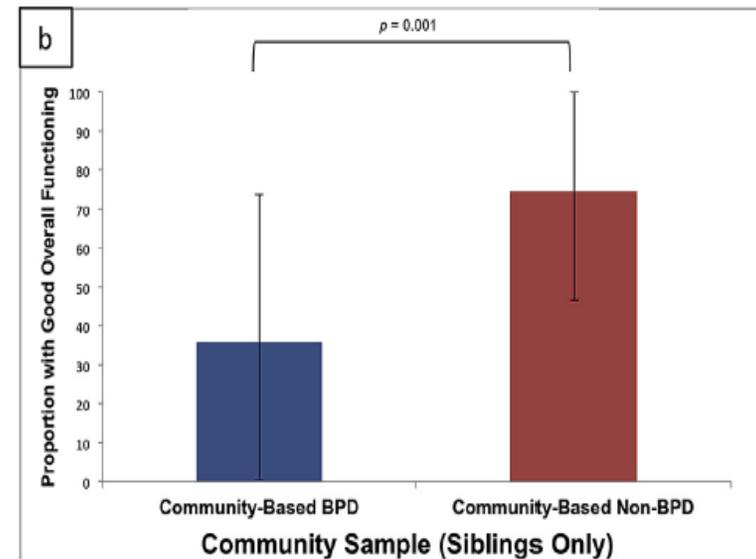
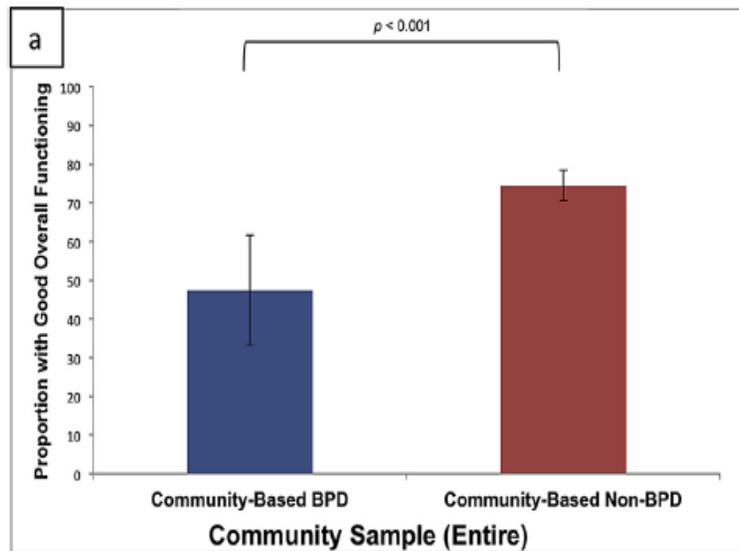


“How to play  
the cards you  
were dealt in  
Life?”

## Functional Remission (GAF > 70 for 12 months): Lifetest survival estimates



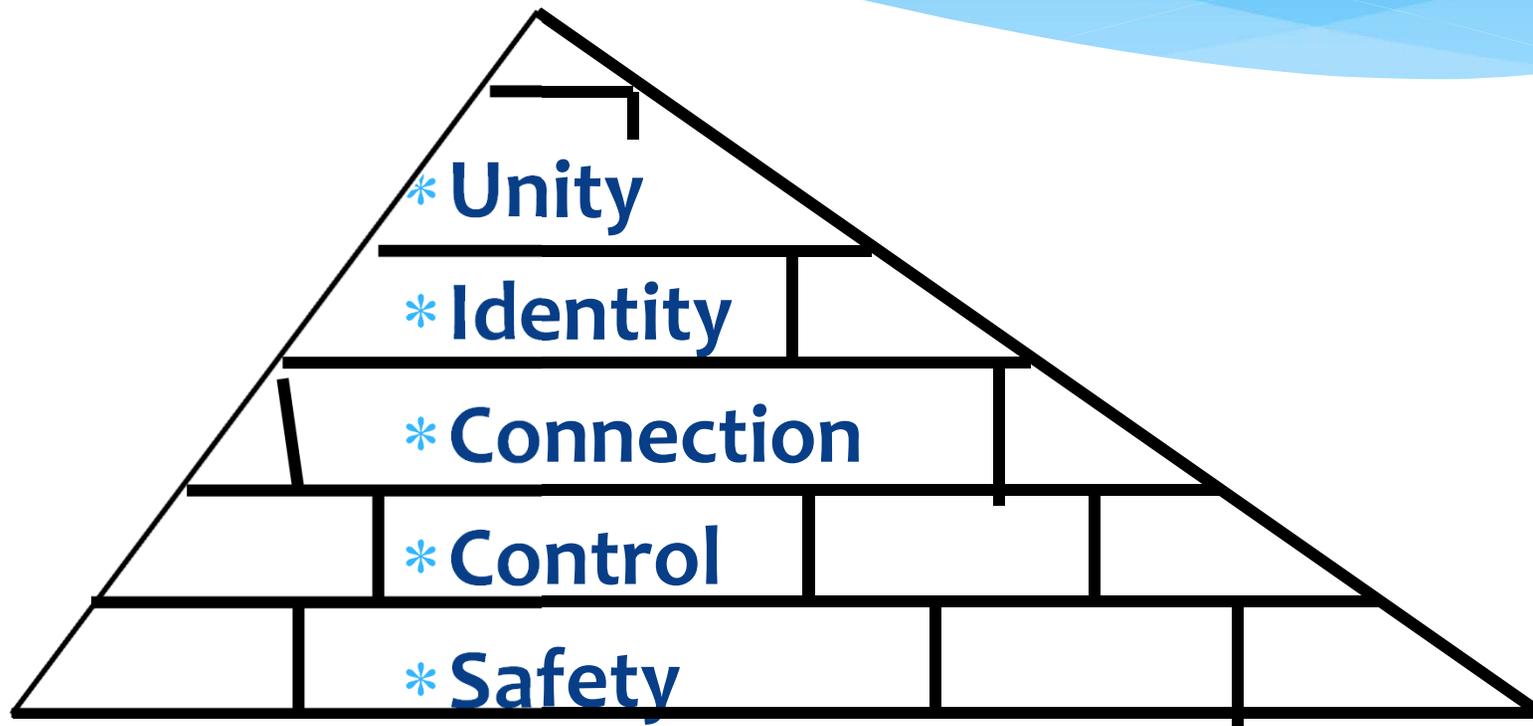
Reduction of suicidal behavior and self-mutilation but still significant mood and anxiety sx's and poor cognitive and inter-relational functioning

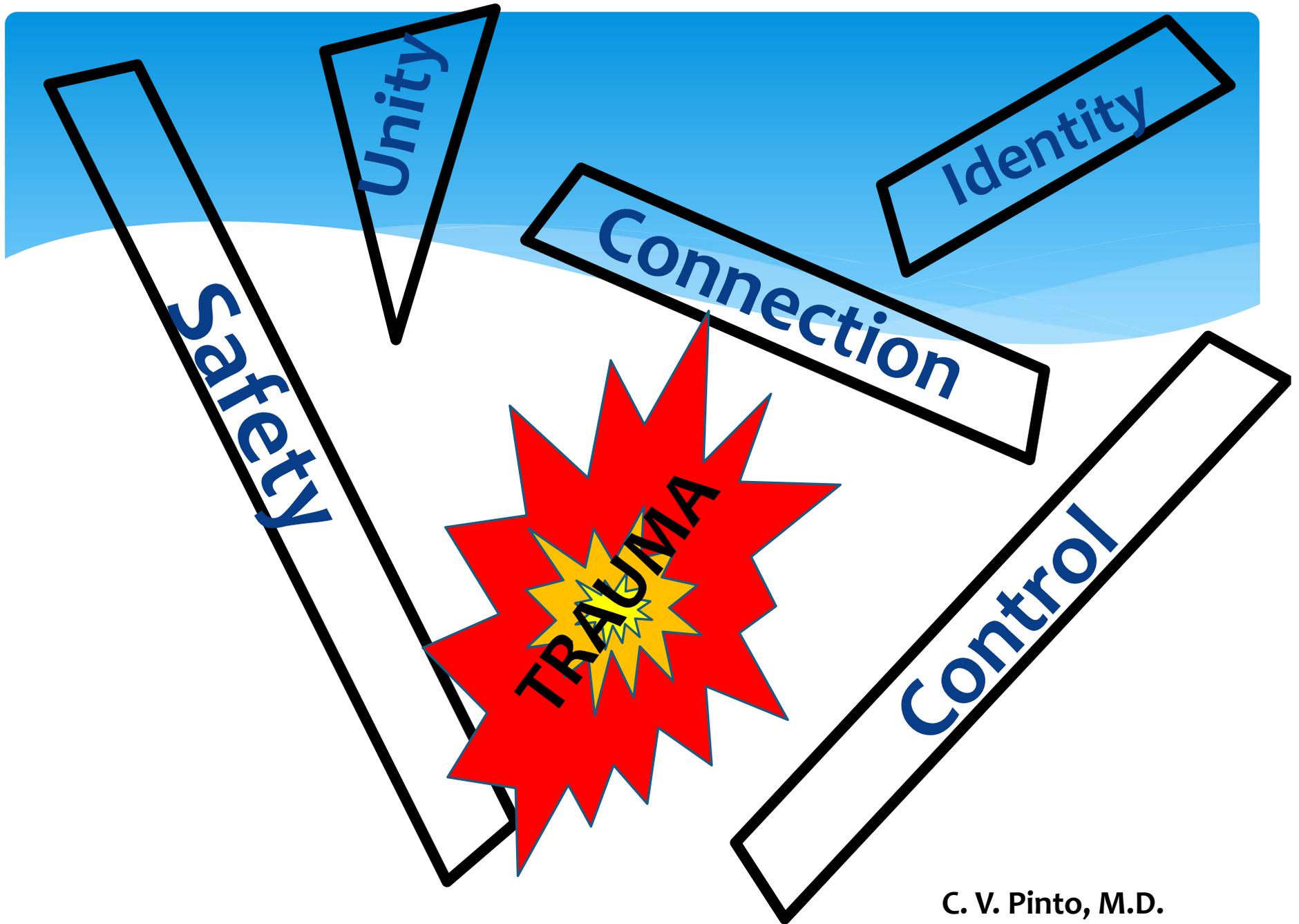


**Functional outcomes in  
community-based adults with  
borderline  
personality disorder**  
Kristin N. Javaras a, b, et. al ,  
Harvard Medical School,  
Journal of Psychiatric Research  
Jan 2017

**Fig. 1.** Estimated proportion with good overall functioning (steady, consistent employment and at least one good relationship) for: a) community-based individuals with borderline personality disorder (BPD) versus general community members without BPD, after adjustment for age, sex, and race/ethnicity ( $n = 164$  and  $902$ , respectively); b) community-based individuals with BPD versus their own (community-based) siblings without BPD, after adjustment for age and sex ( $n = 85$  and  $104$ , respectively); and c) clinically-based individuals with BPD versus community-based individuals with BPD, after adjustment for age, sex, and race/ethnicity ( $n = 61$  and  $164$ , respectively). The cross-bars represent 95% CIs for the proportion with good overall functioning, and the  $p$ -value refers to a test of the null hypothesis that there are no between-group differences in the proportion with good overall functioning.

# Trauma Causes Disruption of a Person's Sense of:





C. V. Pinto, M.D.

# Disruption of Sense of Safety

\* **External**

\* **Internal**

# **Disruption of Sense of Control**

- \*Negative Expectations**
  - \*Self-Reinforcing**
- \*Learned Victim Self-Concept**

# Disruption of Sense of Connection

- \* Attempt to stop the pain
  - \* Relationships are risky
- \* Isolation becomes a prison
- \* Cut off source of healing
  - \* Impairs sense of self

# **Disruption of Sense of Identity**

- \*Faces are the  
mirrors to ourselves**
- \*Distorted mirrors >  
Distorted self-images**

# Disruption of a Sense of Unity

- \*How do I fit? ...

  - \*myself

  - \*others

  - \*the world

  - \*God

# Core Concept

\* Normal people  
exposed to  
**Abnormal Stress!**

# Reframe Your Thinking:

**“What happened to you?”**

**from**

**“What’s wrong with you?”**

**Don’t see a victim but a survivor  
who is still suffering**

# Core Concept

- **Things that increase sense of safety & control will help**
- **Things that decrease sense of safety & control will make person worse**

# 'Polyvagal Theory'

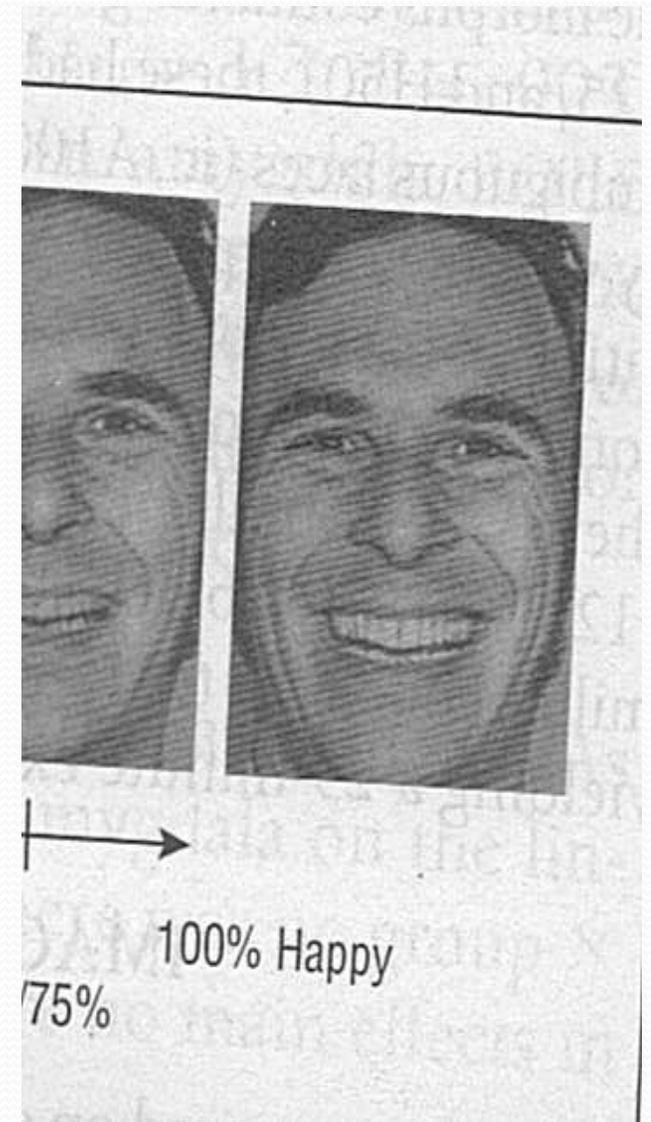
- Our nervous system influences our interactions with others/world and our interactions with others/world influence our nervous system
- We unconsciously project & detect safety (& non-safe) cues through vocalization (intonation/prosody), facial muscles, posture & gestures based on our physiological, neurobiological & psychological state
- We use relationships to help regulate our physiology
- People evolved a stress adaptation method using relationships with others.
- **WE NEED OTHERS TO FEEL SAFE WHEN WE CANNOT MAKE OURSELVES FEEL SAFE.**

Stephen Porges, Brain-Body Center, Univ of Illinois

# Caregiver Neutrality

- Empathy - Cognition without emotion
  - “head but not heart” - Professional Asperger’s
    - Protects Provider by simplifying relationship
    - Protects Patient by simplifying the relationship
      - Nonjudgmental
      - Non rejecting
      - Not vulnerable

# Therapeutic Genuineness



# Therapeutic Genuineness

- Recognizing first you and your patient are human
  - Understanding cognition and emotion are inseparable
  - Recognizing your patient's negative bias
  - Realizing there is a risk in every relationship
- Acknowledge this to yourself and explain it to your patient (risk-benefit analysis)
  - Allowing your self “emotional armor”
- Monitoring and caring for yourself is essential so you can monitor and care for your patient
  - Express appropriate emotion and recognize and apologize for the limits of the relationship

C. V. pinto, M.D.

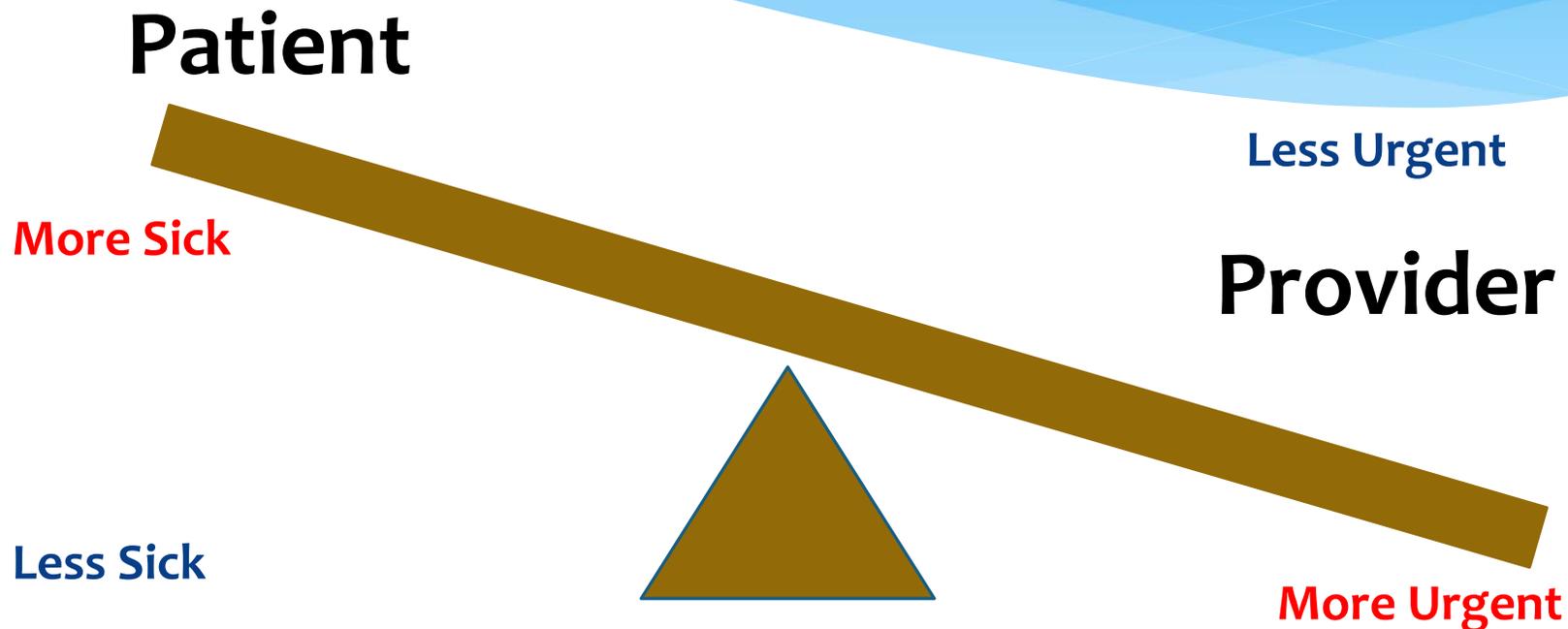
# Transference

\*The set of expectations, beliefs and emotional responses a **patient brings** to the patient-provider relationship

# Countertransference

\*The set of expectations, beliefs and emotional responses a **provider brings** to the patient-provider relationship

# Balance of Power (Decision Making)



**The balance of Power is fluid and dynamic, it is based on many factors**

# Boundaries

- \*Boundaries are the rules of engagement, the agreement that we practice under to keep ourselves and our patients safe, while providing quality care.**

# Boundaries

- \* Fluid

- \* Dynamic

- \* Based on multiple factors

- \* Negotiable and Non-negotiable

- \* Have risk and benefit

- \* therefore, analysis and informed consent can be useful and therapeutic

- \* It is the provider's role to identify and respond to boundary issues

# Patient-Provider Contract

## Provider Contract

### \* First do no harm

- \* Don't have sex with your patients
- \* Don't cheat, lie, exploit, talk about your patients
- \* Don't be mean or vengeful to patients
- \* Don't have favorite patients
- \* Don't socialize with your patients
- \* Practice according to standards and guidelines
- \* Be competent, stay up-to-date, don't work impaired
- \* Refer when appropriate
- \* **Treat patients equally and consistently with your practice rules and boundaries**

# Conceptual framework of Treatment for Borderline Personality Disorder

- \* **Medications** – “Bottom-up” approach: decrease arousal and stress response system
  - \* Serotonin, dopamine, norepinephrine, GABA etc.
- \* **Therapy** – “Top-down” approach: activate prefrontal cortex to process and inhibit limbic system
  - \* practice interpretation reanalysis, relational skills, impulse control, decision making, self-soothing etc.
- \* **Environmental Manipulation** – “Stack the deck for success”: play to strengths and avoid weakness, therapeutic retreat etc.
  - \* Avoid toxic relationships, avoid triggers, practice safe relationships, support systems etc.

# Pharmacological Approach

## All off-label, No FDA Indicated Treatments

- \* Antidepressants – SRI, SNRI, Multi-Modal Agents
- \* Antipsychotics – conventional or atypical, D2 antagonist or D2 partial agonist
- \* Mood Stabilizers/Anticonvulsants
- \* Lithium
- \* Anxiolytics/Sedatives - benzodiazepines , Z-drugs
- \* Noradrenergics – Beta blockers, alpha 1 antag, alpha 2 agonist
- \* Antihistamines – sedating atypicals & ADs, hydroxyzine etc.
- \* Self Medication – ETOH (GABA), caffeine, nicotine, cannabis, opioids, stimulants
- \* Combinations of above



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# Psychopharmacological treatment of 2195 in-patients with borderline personality disorder: A comparison with other psychiatric disorders

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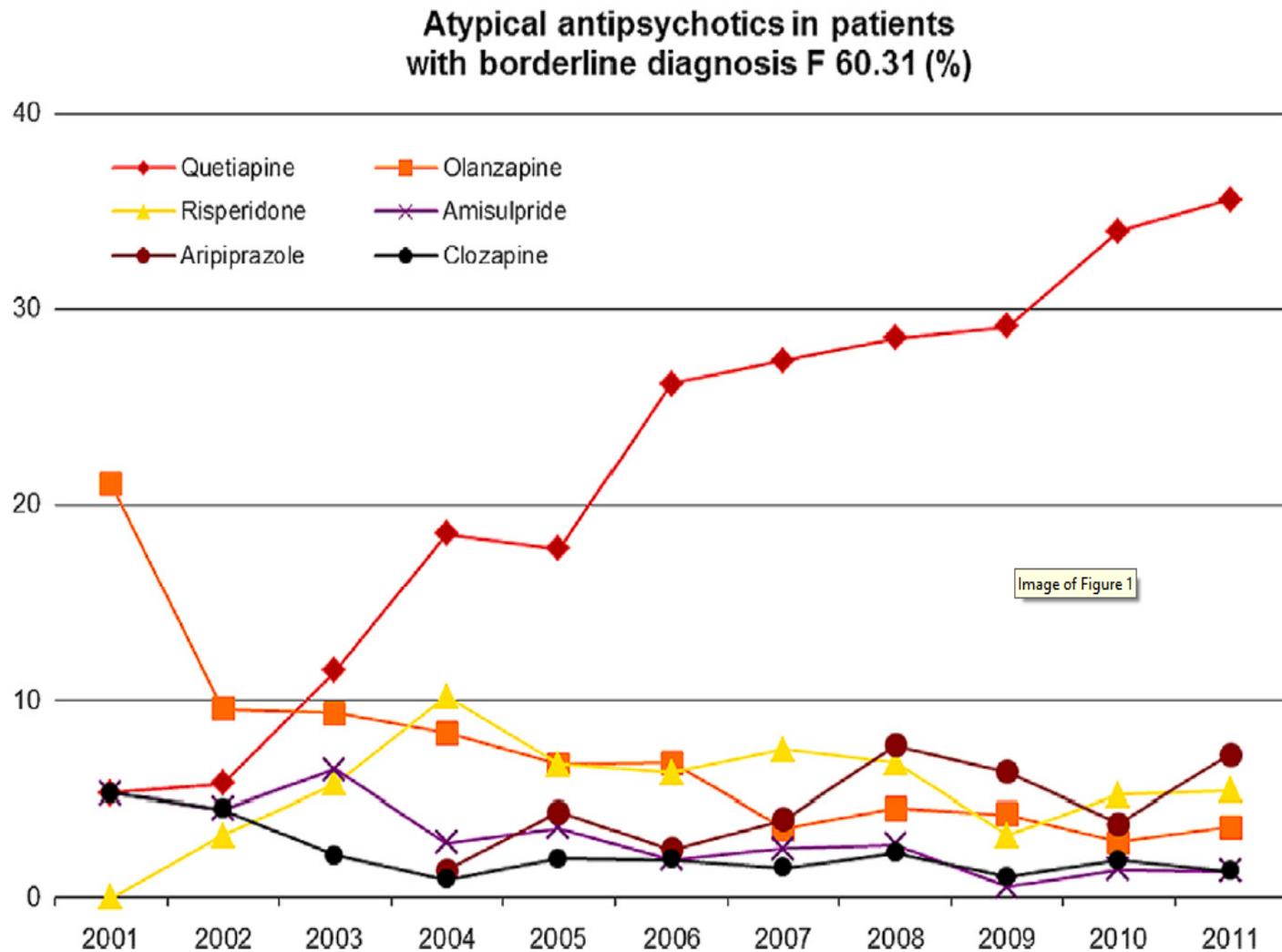
**Table 1** Patients with the diagnosis BPD and drug prescriptions.

	Number of patients		Prescription
<b>Psychiatric diagnoses</b>	Medicated <sup>a</sup>	All	Number
All patients <sup>c</sup>	84,860 (83,084)	88,793	353,796
Borderline type (BPD) F 60.31	2035 (1972)	2195	8088
<b>Psychotropic drugs (F 60.31)</b>	Medicated	% <sup>d</sup>	Number
Antidepressants	1424	70.0	1709
Antipsychotics	1406	69.1	2070
Anticonvulsants	662	32.5	722
Tranquilizers <sup>e</sup>	602	29.6	650
Hypnotics <sup>e</sup>	332	16.3	344
Lithium	87	4.3	87

**Polypharmacy was prevalent – 80%; three or more medications in 54%**  
**Citalopram and escitalopram were the most commonly prescribed antidepressants**  
**Optimize antidepressant dose and then augment with low dose antipsychotic**  
**Controlled medications are high risk**

Consider  
 asenapine  
 5-10 mg hs  
 Sedating,  
 minimal  
 wt gain,  
 has  
 favorable  
 5HT<sub>7</sub> and  
 D<sub>4</sub> activity  
 which  
 might  
 reduce  
 aggression  
 and  
 possibly  
 suicide\*

Pinto & El-Mallakh, 2017



**Figure 1** Prescription rates of atypical antipsychotics for patients with BPD diagnosis F 60.31. Percentages of patient drugs are shown. Logistic regression models show that prescriptions of quetiapine increase significantly with  $y = (1,10) = 83.9$ ;  $p < 0.01$  as well as the prescriptions of aripiprazole:  $y = 0.2x - 428.5$ ;  $\chi^2 (1,10) = 24.6$ ;  $p < 0.01$ . Olanzapine decrease significantly with:  $y = -0.16x + 308.4$ ;  $\chi^2 (1,10) = 20.9$ ;  $p < 0.01$  as well as the prescriptions of aripiprazole:  $y = -0.2x + 340.3$ ;  $\chi^2 (1,10) = 11.7$ ;  $p < 0.01$ . \*R. El-Mallakh, The dopamine D<sub>4</sub>/D<sub>2</sub> receptor antagonist affinity ratio as a predictor of anti-aggression medication efficacy, / Medical Hypotheses 80 (2013) 530-533

**Table 1**  
Correlations of levels of damage

Agent	Study Design	Number of Patients	Treatment Duration	Results
<b>Lithium</b>				
Links <sup>17</sup>	Crossover vs desipramine	10	6 weeks	Decreased irritability/anger, self-mutilation
Stein <sup>18</sup>	Review	NA	NA	Decreased behavioral dyscontrol, aggressiveness
<b>Carbamazepine</b>				
Gardner <sup>20</sup>	Crossover vs placebo	11	NA	Decreased behavioral dyscontrol
Cowdry <sup>21</sup>	Double-blind vs ALP, TFP, TCM	16	6 weeks	Decreased behavioral dyscontrol
Denicoff <sup>26</sup>	Retrospective vs other drugs and ECT	1257	NA	Global improvement
<b>Oxcarbazepine</b>				
Bellino <sup>41</sup>	Open-label	13	12 weeks	Decreased global symptomatology, mood instability, impulsivity/anger, interpersonal sensitivity
<b>Valproate</b>				
Wilcox <sup>43,44</sup>	Case series	NA	NA	Decreased global symptomatology, anxiety/agitation
Stein <sup>45</sup>	Open-label	44	6 weeks	Decreased global symptomatology, mood instability, impulsivity/anger, interpersonal sensitivity

**Bellino, S. et al., Mood Stabilizers and Novel Antipsychotics in the Treatment of Borderline Personality Disorder, Psychiatric Times, July 2006, Vol. XXIII, No. 8**



[Indian J Psychiatry](#). 2010 Jul-Sep; 52(3): 267–269.  
doi: [10.4103/0019-5545.70989](#)

PMCID: PMC2990830

## Treatment of severe borderline personality disorder with clozapine

[Adarsh Kumar Vohra](#)

[Author information](#) ► [Copyright and License information](#) ►

This article has been [cited by](#) other articles in PMC.

### Abstract

Go to:

Patients with borderline personality disorder (BPD) show significant impairment in the domain of interpersonal and social functioning and may use the resources of health and social services extensively, with little beneficial outcome. At present there are no clear guidelines in literature for the use of pharmacotherapy in the management of BPD. According to the scanty literature available in the form of case reports and small studies, clozapine has been demonstrated to be effective in the management of BPD. The case presented here describes the effectiveness of clozapine in a young female patient with severe BPD (without psychotic features), who had repeated and prolonged periods of hospitalization and was successfully treated with a moderate dose of clozapine, following a failure to improve with other psychotropic medications. More studies are suggested to evaluate the efficacy of clozapine in patients with BPD, both with and without psychotic features, to find out the optimum dose and to weigh the risk and benefits of clozapine.

**Keywords:** Case report, clozapine, borderline personality disorder, severe

### INTRODUCTION

Go to:

# ECT for BPD?

Format: Abstract ▾

Send to ▾

[J ECT](#), 2001 Jun;17(2):91-8.

## Is electroconvulsive therapy effective for the depressed patient with comorbid borderline personality disorder?

[DeBattista C](#)<sup>1</sup>, [Mueller K](#).

⊕ **Author information**

### Abstract

Among the more common current indications for electroconvulsive therapy (ECT) is treatment-resistant depression. Treatment resistance is correlated with a number of factors, including the presence of comorbid personality disorders, such as borderline personality disorder (BPD). A detailed review of the literature was undertaken and very few reports or studies have dealt specifically with ECT in borderline patients. Thirteen original reports on ECT outcome in personality disordered patients were identified. Depressed patients with a personality disorder, particularly BPD, may have a poorer outcome on some measures. However, the available data suggests that depression in these patients can be effectively treated with ECT. The depressed, borderline patient appears to have two distinct disorders, one which is responsive to ECT and the other which is not. Unfortunately, the literature is limited by lack of rigorous randomized treatment studies, lack of long-term follow-up, and other methodological weaknesses. Clinical guidelines are suggested.

# TMS for BPD?

- \* In a study described as a pilot trial, Caihol and colleagues (Caihol 2014), reported a randomized, controlled study in which 10 BPD patients received series of 10 sessions of high-frequency rTMS to the right DLPFC. The rTMS treated group **showed improvements in anger, affective instability, anger and planning** (Caihol 2014).

# Principles of Medication Management

- \* **Your relationship is the biggest part of the treatment**
- \* Explain you need to earn his trust & prove your competence
- \* Ask how the patient is 'actively' working to get better
- \* Be Realistic and Genuine – NOT Curative, only palliative
- \* Explain and therapeutically engage patient in medications decisions
- \* Try to only change one drug at a time
- \* Do not rush titration – **Start Low and Go Slow**
- \* See the patient more often – or give responsibility to patient to 'check-in' frequently
- \* Give the patient some control with medication parameters and permission to safely/responsibly 'quit' a medication

# Summary of BPD

## Medication Management

- Many different medications can help a little bit usually at low doses
- Medication might help to “turn down the emotional volume” or “lengthen the fuse before one blows”
- The medication is a tool to allow people to tolerate herself and the environment, while practicing new skills

# Psycho-Social Treatment

- Therapeutic Genuineness
- Constant Positive Regard
  - Caringly Curious
- Engagement: voluntary, involved
  - Boundaries, Contracts, Negotiations
  - Practice, homework

- 
- **Contemplate**
  - **Communicate**
    - **Navigate**
    - **Advocate**
  - **Congratulate**

# No matter what kind of treatment is done, healing from BPD involves the cultivation of the following qualities for ALL involved

**Openness:** A willingness to experience the symptoms without shutting down or defending ourselves unnecessarily

**Validation:** Recognize what each person is saying and experiencing, even if you disagree.

**Pausing and imagining what others are feeling:**

The pause allows us to respond rather than react

**Mindfulness:** Developing awareness of body, feelings, thoughts, reactions, & surrounding environment



**Patience:** Allowing ourselves and others to go through the process and accept it won't be on our schedule

**Non-judgment:** Not imposing our own viewpoint but focusing on facts

**Giving the Benefit of the Doubt:** Not jumping to conclusions about other people's behavior

**Curiosity:** Asking "what is going on" rather than making judgments and assumptions

**Hope:** Believing that recovery is possible



**Often the Relationship begins in testing boundaries through acting out**

**Be prepared to maintain consistency and not be frustrated. Appreciate your patient's ingenuity and creativity**



# Patient-Provider

## Relationship Problems

- Saying “No” therapeutically
  - Setting Limits
  - Over expectations
- Not feeling safe with a patient
  - Dependency
  - The angry patient
  - The helpless patient

## 5 Things Not to Say To Someone with BPD

***"Other people  
have it worse."***

*"You need  
to grow  
up."/ "Stop  
acting like  
a child."*

*"You're too  
sensitive/over  
dramatic/you  
exaggerate."*

*"Stop playing  
the victim/  
take more  
responsibility  
for yourself."*

***"Self harm is  
disgusting/  
stupid/  
attention  
seeking."***

# Do Not Steal a Patient's Insight

- The most important thing isn't that you know the cause of the problem, or the answer to the problem ... it is if the patient knows
- Be patient and let the patient progress at his or her own pace

# Dialectical Behavior Therapy

## Mindfulness

Being focused and learning to live in the present moment.

## Regulating Emotions

Reduce the intensity of emotional pain until the feelings pass.

## Distress Tolerance

Learn to defuse stressful or painful situations resulting in better health.

## Interpersonal Effectiveness

Understand how to set boundaries and clearly express your needs.



## NIH Public Access

### Author Manuscript

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*J Psychiatr Res.* 2014 October ; 57: 108–116. doi:10.1016/j.jpsychires.2014.06.020.

## Dialectical behavior therapy alters emotion regulation and amygdala activity in patients with borderline personality disorder

Marianne Goodman<sup>a,b,d,\*</sup>, David Carpenter<sup>c</sup>, Cheuk Y. Tang<sup>c</sup>, Kim E. Goldstein<sup>a</sup>, Jennifer Avedon<sup>b</sup>, Nicolas Fernandez<sup>b</sup>, Kathryn A. Mascitelli<sup>b</sup>, Nicholas J. Blair<sup>b</sup>, Antonia S. New<sup>a,b</sup>, Joseph Triebwasser<sup>a,d</sup>, Larry J. Siever<sup>a,b,d</sup>, and Erin A. Hazlett<sup>a,b</sup>

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<sup>c</sup>Department of Radiology, Icahn School of Medicine at Mount Sinai, USA

<sup>d</sup>Outpatient Psychiatry, James J. Peters VA Medical Center, Bronx, NY, USA

### Abstract

**Objective**—Siever and Davis' (1991) psychobiological framework of borderline personality disorder (BPD) identifies affective instability (AI) as a core dimension characterized by prolonged and intense emotional reactivity. Recently, deficient amygdala habituation, defined as a change in response to repeated relative to novel unpleasant pictures within a session, has emerged as a biological correlate of AI in BPD. Dialectical behavior therapy (DBT), an evidence-based treatment, targets AI by teaching emotion-regulation skills. This study tested the hypothesis that BPD patients would exhibit decreased amygdala activation and improved habituation, as well as improved emotion regulation with standard 12-month DBT.

## Dialectical Behavioral Therapy – Skills Training Quick Reference List

<p><b><u>Skills Training AAA Model</u></b>  <b>A</b>wareness  <b>A</b>cceptance  <b>A</b>ction</p>	<p><b><u>Emotion Regulation Goals</u></b></p> <ul style="list-style-type: none"> <li>• Understand Emotional Experience</li> <li>• Reduce Emotional Vulnerability</li> <li>• Decrease Emotional Suffering</li> </ul>	<p><b><u>Problem Solving</u></b></p> <ol style="list-style-type: none"> <li>1. Identify Problem</li> <li>2. Gather Data</li> <li>3. Analyze Data</li> <li>4. Find Solution</li> </ol> <p><b>Validate</b>  <b>Imagine</b>  <b>Take small steps</b>  <b>Applaud yourself</b>  <b>Lighten your load</b>  <b>Sweeten the pot</b></p>								
<p><b><u>Mindfulness</u></b></p> <table border="0"> <tr> <td><b>How Skills</b></td> <td><b>What Skills</b></td> </tr> <tr> <td>One-mindfully</td> <td>Observe</td> </tr> <tr> <td>Non-judgmentally</td> <td>Describe</td> </tr> <tr> <td>Effective</td> <td>Participate</td> </tr> </table>	<b>How Skills</b>	<b>What Skills</b>	One-mindfully	Observe	Non-judgmentally	Describe	Effective	Participate	<p><b><u>Emotion Regulation</u></b></p> <p><b>Physical activity</b>  <b>Illness treatment</b>  <b>Eat balanced meals</b>  <b>Avoid mood-altering drugs</b>  <b>Sleep balance</b>  <b>Exercise</b></p> <p><b>Mindful to emotion</b>  <b>Action opposite to emotion</b>  <b>Self-validation</b>  <b>Turn the mind</b>  <b>Experience building positives</b>  <b>Radical acceptance</b></p>	<p><b><u>Setting Goals</u></b></p> <p><b>Specific</b>  <b>Meaningful</b>  <b>Achievable</b>  <b>Recordable</b>  <b>Timeline plan</b></p>
<b>How Skills</b>	<b>What Skills</b>									
One-mindfully	Observe									
Non-judgmentally	Describe									
Effective	Participate									
<p><b><u>Distress Tolerance</u></b></p> <p><b>Activities</b>  <b>Contributing</b>  <b>Comparisons</b>  <b>Emotion opposites</b>  <b>Pushing away</b>  <b>Thoughts</b>  <b>Sensations</b></p> <p><b>Imagery</b>  <b>Meaning</b>  <b>Prayer</b>  <b>Relaxation</b>  <b>One thing at a X</b>  <b>Vacation</b>  <b>Encouragement</b></p> <p><b><u>Pros &amp; Cons</u></b></p> <p><b>Temperature</b>  <b>Intense physical exertion</b>  <b>Paced breathing</b></p> <p><b><u>Self Soothe with the Senses</u></b></p> <table border="0"> <tr> <td>Taste</td> <td>Smell</td> <td>Sight</td> </tr> <tr> <td>Hearing</td> <td>Touch</td> <td></td> </tr> </table>	Taste	Smell	Sight	Hearing	Touch		<p><b><u>Interpersonal Effectiveness</u></b></p> <p><b>Describe</b>  <b>Express</b>  <b>Assert</b>  <b>Reinforce</b></p> <p><b>Mindful</b>  <b>Appear confident</b>  <b>Negotiate</b></p> <p><b>Gentle</b>  <b>Interested</b>  <b>Validate</b>  <b>Easy manner</b></p> <p><b>Fair</b>  <b>Apology free</b>  <b>Stick to values</b>  <b>Truthfulness</b></p>	<p><b><u>Relapse Prevention</u></b></p> <ul style="list-style-type: none"> <li>• Practice Skills Daily</li> <li>• Enhance Positive States</li> <li>• Disregard Social Pressure</li> </ul> <p><b><u>Thought Modification</u></b></p> <ul style="list-style-type: none"> <li>• Turn the Mind</li> <li>• Radical Acceptance</li> <li>• Willingness</li> </ul> <p><b><u>Behavior Chain Analysis</u></b></p> <ol style="list-style-type: none"> <li>1. Prompting event</li> <li>2. Problem thought</li> <li>3. Problem emotion</li> <li>4. Target Behavior</li> <li>5. Short term Relief</li> <li>6. Long term Consequence</li> </ol>		
Taste	Smell	Sight								
Hearing	Touch									

# How can a person turn off the stress response?

- \* **P** Physical problems
- \* **L** Lifestyle, Laugh, Learn
- \* **E** Exercise, (Joyful movement)
- \* **A** Avoid Toxins (SA, OTCs, Relationships)
- \* **S** Sleep Hygiene, Sex, Singing
- \* **E** Eat Healthy (Food is Medicine)
- \* **S** Spirituality, Safe Relationships, Self Talk

# Physical Illness

**Physical illness activates the brain and body stress response system, which if overactive or prolonged will wear down your mental and physical health.** Health promoting chemicals are reduced and toxic chemicals are increased. The nutritional building blocks we absorb from food are “hijacked” from health promoting systems and used to fuel inflammatory systems which increase the risk of illness and decrease the chance of getting well. Physical and mental illness is like gas on fire (fire represents the illness and gas represents physical or mental stress/illness). Please see your primary health care provider regularly and be prepared with a list for your symptoms and complaints. In addition take the bottles of all your medications including vitamin/herbs and over-the-counter drugs. Take your medications only as prescribed and report any problems including weight, sexual problems or cost. Pets can help people feel less lonely and help them live longer.

# Lifestyle

- **Lifestyle is important in stress response activation and can affect health and disease in either a good way or a bad way. Think about and try to develop a low-stress lifestyle. Try to avoid creating behaviors and situations such as arguing, worrying and getting upset, while trying to increase stress-reducing behaviors and situations such as relaxation, fun, support, therapy etc. **Not only do you not want to put “gas on the fire,” you want to put “water” (water represents fun, relaxation or feeling safe) on the “fire” to put it out or make it smaller. When we laugh or act and feel joyful then we shut down the inflammatory stress system and activate health promoting systems. Think positive because the brain automatically thinks negatively when under stress. Your brain is wired to focus on danger and ignore the good that is all around us. This phenomena presents itself as depression and anxiety. As our brains and bodies experience more joy and less stress, they have the remarkable ability to improve and even heal some diseases! Laughing turns on healthy systems and shuts down the stress response. Learn and practice laughing deep and often, all around us life is full of joy.****

# Eat Well

**Eat well, what you eat fuels your brain and body, providing the nutritional building blocks to grow and be healthy.** Eat in moderation; too much or too little of almost any food is not ideal. A balanced diet is essential, one that is high in fruit, vegetables, and fiber, with lower portions of meat, fat, and sugar. Eat small, healthy meals/snacks throughout the day, eat slowly, chew your food well, and savor the taste. Start to pay attention to your eating and be mindful of it, as it is one of the simplest joys in life and one of the most important things you do every day. Try to get your vitamins and minerals from fresh, whole, unprocessed foods. Flash frozen foods with minimal additives, (like frozen fruits and vegetables without extra sugar or syrup) are also a good source of nutrition. Breakfast is an important meal and low calorie oatmeal, bran flakes or granola cereal is a good choice. Prepare your food with less fat or butter, and add flavor with spices while trying to keep salt to a minimum. You do not have to be perfect and can “splurge” or cheat occasionally. Remember, try to spend your calories wisely, and enjoy what you eat. Gulping down a drive-through hamburger, while driving and talking on your cell phone is extra calories you won't enjoy or remember until they show up on your waistline. Nutritional supplements may be helpful but should not be a substitute for good eating. For many people a daily multivitamin, vitamin B complex, a vitamin D supplement and omega-3 fatty acids from fish or flax seed can promote good health and lower disease risk.

# Avoid Toxins

**Avoid toxins and toxic people/relationships. Toxins like alcohol, street drugs, nicotine, caffeine and sugar can activate the stress response system and reduce health promoting systems. Alcohol and drug use, even casually, can significantly reduce the chance of success with your prescribed medical treatments. Alcohol, nicotine and drugs can also increase the risk of disease, hospitalizations, accidents and suicide. Alcohol and other drugs can interact in the liver, brain and kidneys with many different medications altering the medication blood levels or effects. It can also make it harder for your health care provider to make the right choice and dose of medication for your condition. Toxic people/relationships can be some of the largest stresses in some people's lives. Not all toxic people/relationships can be completely avoided, therefore, learning and practicing how not to feel guilty or take responsibility for other people's problems is important to health promotion.**

# Sleep hygiene.

Sleep is very important to health. Sleep patterns will change as we get older. As we get older we will not sleep as deeply or soundly. We will sleep for a shorter time throughout the night, and we will tend to get sleepy earlier in the evening and tend to wake up earlier in the morning. Poor sleep or insomnia is very common. Insomnia can involve difficulty falling asleep, staying asleep, or having day and night cycles mixed up. Poor sleep increases depression, anxiety, and pain; as well as interfering with attention, coordination and memory. Over-The-Counter (OTC) sleep aids or alcohol may make people feel sleepy, but generally do not produce good sleep and may be habit forming. It takes time and work to improve your sleep pattern. Start by making sure your bedroom is comfortable, dark, quiet, and at the right temperature. **Needing to use the bathroom and pain are the two most common reasons people wake up during the night,** so empty your bladder before bed and find a comfortable position to sleep with a good pillow and mattress. Do not eat or drink for a few hours before going to bed. Try to wind-down for a few hours before bed and practice breathing and relaxation techniques when you are trying to fall asleep. **Worry is the main reason people have trouble falling asleep,** so it may help to make a list of problems and things you need to get done during the day so you can try to relax at bedtime. Try not to nap during the day, and if you do nap, try to keep it under 40 minutes. Exercise during the day can help you sleep better at night. Exercise (walking) before noon, outside, exposed to the sun can help reset your sleep cycle over 3-4 weeks. If you still have trouble sleeping, talk to your health care provider about a sleep study to evaluate your sleep and rule out any medical problems interfering with your sleep. Singing activates healthy parts of your brain and reduces the stress response. Spirituality and praying help many people feel less stressed and some studies have actually shown spirituality may actually increase brain growth.

# Exercise

- **Exercise is important for physical and mental health.** People who are inactive have increased risk for depression, insomnia and increased pain sensitivity. Studies have shown that simple exercise, such as brisk walking for 40 minutes three times a week can reduce brain shrinkage and increase brain growth, while improving memory, health, and life expectancy. **Exercise actually practices the stress response and can help to recondition the stress response so that it turns on and off appropriately. Exercise can improve mood, anxiety and thinking.** Both aerobic (walking) and resistance (light weight lifting) are important to improve health, energy, appetite, and weight control. **Exercise is most stress-reducing when it is joyful** (like dancing or walking a dog). Being active throughout the day is a good habit to develop. Walking up and down stairs instead of taking the elevator, or getting up to change the channel instead of using the remote can be a start.



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# Suicide and Self-Mutilation

- **High Risk** – Ask, anticipate
- Not all self harm is suicidal
- Safety and Control issues for client:
  - Comfort, release, revenge etc.
- Safety & control issue for provider:
  - “Emotional Hostage”, projective identification
- Negotiate boundaries (probation)
- **Know your threshold to act**

## What Can Family Members Do?

### 1. Understand the emotion process of BPD

- Knowing what is going on reduces negative reactivity and improves empathy, even in challenging situations
- Even being able to give a process a name, such as "emotional cascade" can help

### 2. Help your loved one distract when upset

- Work with them to come up with activities that they enjoy and are willing to do when distressed
- Develop a "coping card" of distracting activities, it is easy to forget strategies when you are distressed

### 3. Try not to get frustrated

- When we get frustrated, which can be easy at times, that can feed into the emotion dysregulation process
- Building emotion regulation skills takes time!

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# Borderline Personality Disorder

FOR  
**DUMMIES**

## Learn to:

- Recognize and understand the symptoms of BPD
- Choose the best forms of treatment
- Overcome obstacles to change
- Find support for loved ones

**Charles H. Elliott, PhD**

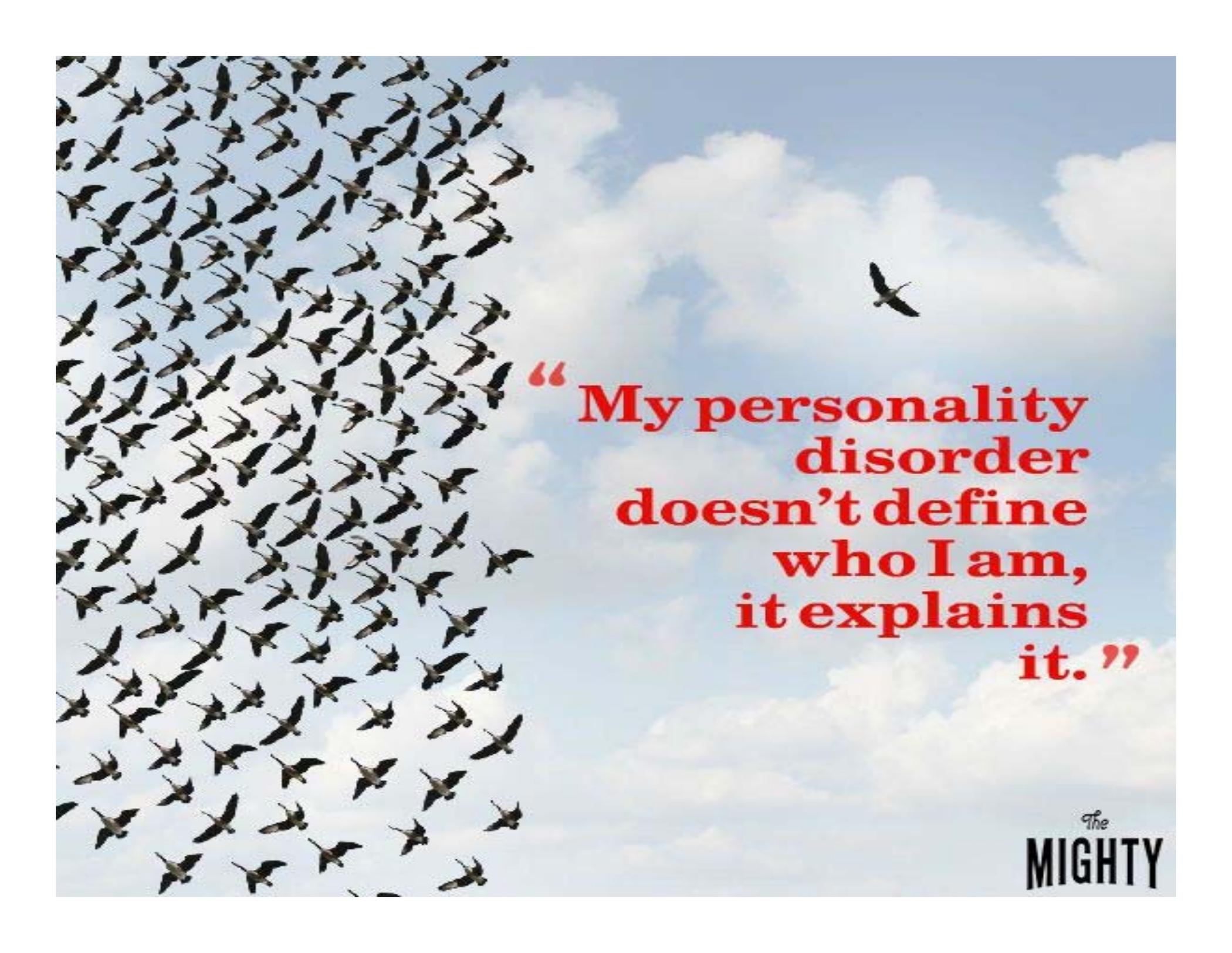
Founding Fellow, Academy of Cognitive Therapy

**Laura L. Smith, PhD**

Chief Psychiatrist

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**“My personality  
disorder  
doesn’t define  
who I am,  
it explains  
it.”**

*The*  
**MIGHTY**

# Healthy Coping Skills

For both patient and Provider

- \* Humor
  - \* Journal, Groups
  - \* Work, Hobbies
  - \* Exercise, Music
- \* Helping – Volunteer
- \* Healthy Family & Friends
  - \* Pets, kids, plants
  - \* Spirituality

# What We do is Hard,

However, People with BPD need us

- Personal and Professional growth is a journey
- You will never be perfect, because you are human
- Mistakes are opportunities to be better, it is how we learn
- Beyond a wholesome discipline, be gentle with yourself
- **Model for your patients: Practice what you preach**

# William Osler

‘The Father of Modern Medicine’

1849 - 1919

- Life is Short
- The Art is Long
- Opportunity is Fleeting
- Experience is Delusionary
  - Judgment is Difficult

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