Important Considerations

▲ The disorder is heterogeneous with many “looks” or presentations.
▲ Medication effects are usually modest at best, and can have negative effects as well (in particular, in negative long-term medical consequences). Meds often target anxiety, depression, mood swings, and impulsivity. However, there is no medication that improves relationships, and none specifically for BPD. NO medication has been approved (FDA) to treat BPD per se.
▲ BPD rarely stands alone. Many other disorders co-occur.
▲ BPD affects between 1.5 and 3% of the population (or more). This equals or exceeds the number diagnosed with schizophrenia or bipolar I disorder.
▲ Estimates are that 10% of psychiatric outpatients and at least 20% of psychiatric inpatients have BPD.
▲ BPD affects men and women, although women are more often given the diagnosis. This may reflect that women more often seek treatment, that anger is more acceptable in men, and that men with similar problems often end up in prison and receive a diagnosis of antisocial personality disorder.
▲ At least 80% have self-injured
▲ Ten percent of BPD patients complete suicide.
▲ However, most people with BPD do get better with appropriate treatment!

BPD Funding and Resources

<table>
<thead>
<tr>
<th></th>
<th>BPD</th>
<th>Schizophrenia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Research papers 1980-2002</td>
<td>2,046</td>
<td>26,265</td>
</tr>
<tr>
<td>Research Funding</td>
<td>$6M</td>
<td>$300M</td>
</tr>
</tbody>
</table>

Treatment Settings for Borderline Personality Disorder

1. Inpatient/residential treatment: general psychiatry vs. specialty unit
2. Outpatient treatment: general outpatient vs. specialty clinic
3. Partial hospitalization / day treatment: general vs. specialty

Types of Treatment

In addition to the treatment setting, there are also different kinds of treatment. These include:
1. Dialectical Behavior Therapy (DBT) – (Linehan et al) Empirically supported
2. Mentalization (UK) – (Bateman, Fonagy et al) Empirically supported
3. “Good” Psychiatric Management – (Gunderson et al) Empirically supported
4. Many treatments do not work well (all are NOT equal)
5. Specialized treatments always outperform treatment as usual
6. “Treatment as usual”: typically has poorest outcomes
### BPD-specific problems are hard to treat, and even more complicated in tandem with co-occurring disorders. BPD rarely stands alone

#### Co-occurring Problems
- ▲ Major Depressive Disorder 70-90%
- ▲ Dysthymia ~70%
- ▲ Eating Disorders (anorexia/bulimia) ~25%
- ▲ Substance Use Disorders 25-40%
- ▲ Bipolar I Disorder ~10%
- ▲ Antisocial PD ~25%
- ▲ PTSD 25-40%

#### Other Disorders plus BPD
- ▲ Major Depressive Disorder 15%
- ▲ Bulimia 20%
- ▲ Eating Disorders 20%
- ▲ Substance Use Disorders 10%
- ▲ Bipolar Disorder (I or II) 35%
- ▲ Other Personality Disorders 50%

#### Expressed Emotion Study
Higher emotional involvement predicted better clinical outcomes. This means that the more emotionally involved the key relatives were, the better the patient fared (fewer hospitalizations). *(Hooley & Hoffman, 1999)*

A goal of *Family Connections* is to teach how to be emotionally involved effectively.

### Finding a Balance: Taking care of others and taking care of ourselves

#### Family Member Well-being
Families who have a relative with BPD report higher levels of burden, depression, and grief than do family members who have a relative with schizophrenia. *(Hoffman et al., 2004)*

How might we understand this?
What are the sources of stress and burden?
**Etiology**

1. People with BPD likely have emotional vulnerabilities to the social, cultural and family environments they are born into, making dysregulation more likely.

2. There are factors in the environment that transact with these vulnerabilities that may make dysregulation more or less likely. *(See figure on Page 12, and Fruzzetti et al, 2005; Fruzzetti & Worrall, 2010)*

**Stressors for Mental Health Care Providers**
- Patient suicide attempts, threats of suicide, anger *(Hellman, 1986)*

**Stressors for Family Members**
- PTSD (mostly around suicide attempts) *(Hoffman, Harned, Fruzzetti, 2016)*

---

- **High emotional sensitivity**
  - Immediate reactions- React quickly
  - Low threshold for emotional reaction- React sooner
    - The person is highly sensitive to emotional stimuli.
    - They react quickly and notice emotional things that others don’t notice
    - Big emotional events hurt more
    - Typically, it takes fewer stimuli for them to feel emotions than another person.
    
    It’s like an open wound on your hand: It feels the intensity of heat more than the rest of the hand.

- **2. High emotional reactivity**
  - Extreme reactions- More intense
  - High arousal dysregulates cognitive processing- Thinking and problem-solving are impaired.
  - The magnitude of the response to the emotional stimuli is higher than that which other people experience.

- **3. Slow return to baseline**
  - Long-lasting reactions - Longer time to recuperate
  - Contributes to high sensitivity to next emotional stimulus, and leaves the person more vulnerable to the next emotional event.

  It takes a longer period of time for the person’s emotional state to return to a more centered place. This creates a fertile ground for the next upset to occur. It’s like trying to walk on a broken leg before it heals; it’s more apt to break again.
Environmental Factors

- 25-60% of BPD patients report having been sexually and/or physically abused as a minor, by a variety of people/relationships.
- Experiencing a loss or abandonment as a child (perceived or actual)
- Poorness of fit – difficulty - between the child and one or more of their environments. The child experiencing one of these environments as invalidating.

How can a Social or Family Environment be Invalidation?

- De-legitimizes one’s experiences, especially private ones (emotions, wants, and desires, thoughts, beliefs, sensations).
- Invalidates those experiences, ESPECIALLY when they are quite discrepant from other people’s experiences.
- Does not accept or appreciate differences.
- Tries to change or control –
- Ignores or doesn’t pay attention.
- Is critical or judgmental.
- Does not communicate acceptance and caring, even if that acceptance and caring exists.
- Hinders problem solving, problem management, and coping -

List 2-3 invalidating AND validating environments your family member experienced growing up.

Stigma

In general, there is stigma about families of persons with mental illness.

However, there also seems to be “surplus stigma” around BPD in part because of the issues of abuse.

What is the stigma with this disorder?

What stigma have you or your family member encountered?
Practice Exercises

1. What was your relative like when he/she was a child?
   a. What adjectives best describe his/her temperament? (one word)
   b. What was he/she like to “soothe”? (one sentence)

2. What is your relative like now?
   a. What adjectives best describe his/her temperament? (one word)
   b. What is he/she like to “soothe”? (one sentence)

3. Bring in two examples of your own emotional reactivity patterns tracking each of the following:
   a. High reactivity
   b. High intensity
   c. Slow return to baseline

4. Think about your relative now in terms of emotional reactivity patterns:
   a. High reactivity
   b. High intensity
   c. Slow return to baseline

5. What environmental factors do you think were present for your relative when he/she was growing up? (one sentence)
Families Cannot Go It Alone

Joel Paris, MD

Families have long been the mainstay for their relatives with mental illness. Families impacted by borderline personality disorder (BPD) are no exception. However, their plight is three decades behind families whose lives have been altered by other psychiatric illnesses. What was once the horror of being vilified as a schizophrenogenic mother was replaced then by being a victim, a parent with a brain disordered child.

BPD parents are not so fortunate in that respect. Often portrayed as individuals high in affectivity, high in borderline traits, high in substance use disorders with their own suspected levels of pathology, parents of BPD sufferers are often described as perpetrators of verbal, emotional, sexual abuse, and/or of neglect.

Certainly we cannot summarily dismiss all allegations and, surely, in some families, great injustices to say the least, were done; in many others there is relatively little evidence of malevolence.

Just as the illness of BPD is heterogeneous from many aspects, so are the families of BPD sufferers. Rather than continually pointing a finger of blame, we need to find a balance as we invite families to engage in the recovery of their relatives. Family matters!

Conversely, due to the severity, symptomatology, and high rates of co-occurring disorders, BPD not only affects the diagnosed but also affects family members and others in their social environment. Families cannot go it alone. Unfortunately, relatively few professionals have included family members in the treatment process.

Etiology of BPD

John G. Gunderson, MD

Like other major psychiatric disorders, the etiology of the borderline personality disorder (BPD) involves both genes and environment. The genetic component, which has been underappreciated, is substantial. It is not, however, the disorder itself which is inherited. Rather, what is inherited are forms of temperament that predispose a child to develop this disorder. The predisposing temperaments (aka phenotypes) for BPD are Affective Instability, Impulsivity, and Needy/Fearful Relationships.

Each of these temperaments predisposes to other disorders as well as BPD: Affective Instability also predisposes to mood disorders; Impulsivity also predisposes to substance / alcohol abuse, bulimia, and conduct disorder; and Needy/Fearful Relationships also predispose
to histrionic, dependent, and avoidant personality disorders. The presence of these inherited temperaments helps explain why patients with BPD are often co-morbid with these other disorders.

Still, these predisposing temperaments do not by themselves explain the etiology of BPD. They make it possible for someone to develop this disorder.

To develop BPD also requires unfortunate environmental conditions. Most theories believe that early caretaking experiences are very important. Here, patients who have BPD will often report that their parenting was inconsistent, neglectful, or even malevolent.

This perspective is deeply distressing to parents. Some parents will feel deeply guilty as they review the past and elaborate on their failures. Others will dismiss the accusations, deny having any role, and thereby add to their borderline offspring’s alienation.

Early caretaking relationships are significantly shaped by the child. This contrasts with the more widely recognized belief that parental interactions significantly shape the child. Thus, the easily upset, needy/fearful, hyperactive child who possesses the predisposing temperaments for BPD will pose special problems for parents. Such a child will benefit from forms of parenting that may not come natural to their parents.

The easily upset child may need an unusually calm and patient caretaker. In its absence their emotions may be poorly integrated and disturbing to them. The needy/fearful child may require a consistently involved, reassuring caretaker. In its absence, their fears of abandonment may become unrealistic. An impulsive child may need parenting marked by predictability and non-punitive limit setting. In its absence, they may not develop self-controls.

Regardless of the early childcare, the child with predisposing temperaments for BPD will be far more easily undone by traumatic events. Most children with trauma grow up without sequelae. Those who suffer enduring consequences from trauma have both a predisposing temperament and -- perhaps due to problematic early caretaking -- will often have failed to disclose and process the event with their caretakers.

It is not easy to develop BPD. I expect that only a small fraction of the people who have the genetic disposition go on to develop it. Parenting is sometimes dysfunctional, but villains are truly rare. We need far more research to understand the contributions of both genes and environment.
Transactional Model of the Development of BPD and Related Disorders

Emotion Vulnerability
(Current biology, baseline, AND temperament, such as sensitivity, reactivity, slow return to baseline)

Pervasive History of Invalidating Responses

Event

Judgment

Heightened Emotional Arousal
(→ emotion dysregulation)

Inaccurate Expression & Out of Control Behavior

Invalidating Responses (From Yourself and Others)

Adapted from Fruzzetti, Shenk, & Hoffman, 2005, Fruzzetti, 2006)