

BORDERLINE PERSONALITY DISORDER IN ADOLESCENTS

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Janis Joplin

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Borderline personality disorder (BPD) is characterised by a pervasive and persistent pattern of instability and impulsivity. BPD has enjoyed much research attention for several decades both in terms of understanding it and tackling it. Whilst the label of BPD is frequently used in clinic settings dealing with teenagers its use in the young remains controversial. Nevertheless, many believe that a set of converging arguments makes its use legitimate in this age group (Miller et al, 2008).

From a didactic perspective, this chapter uses the concept of BPD as defined in DSM 5. However, readers need to be aware of the risks of this reductionism in relation to other conceptualizations of the condition. In this chapter we highlight the high frequency of the disorder in adult and adolescent populations and its psychosocial consequences. A large section is dedicated to diagnosis and differential diagnosis. The chapter finishes with a description of useful treatment strategies.

EPIDEMIOLOGY

Prevalence

Prevalence of BPD is estimated to be between 0.7% and 1.8% (Swartz et al, 1990; Torgersen, 2001). A general population study involving about 35,000 participants found a lifetime prevalence for BPD of 5.9% using the Alcohol Use Disorder and Associated Disabilities Interview Schedule-DSM-IV version (Grant et al, 1995). Within clinical populations, US data show a prevalence of 6.4% in general medical samples (Gross et al, 2002), and from 10% to 23% in out-patients suffering from mental health problems (Korzekwa et al, 2008; Swartz et al, 1990), and 20% among psychiatric inpatients.

Data are scarce for children and adolescents and samples are much smaller. A French study found a high prevalence of BPD in adolescents (10% in boys and 18% in girls) as measured by the DIB-R (Diagnostic Interview for Borderlines – Revised) adapted for adolescents (Chabrol et al, 2001a). A Chinese study reported a more modest prevalence of 2% (Leung & Leung, 2009).

Gender and culture

Currently, prevalence in the general population is considered to be similar for both genders (Leichsenring et al, 2011). In clinical populations, females represent three quarters of all patients. Some experts hypothesize this may be due to men's difficulty accessing care, particularly psychotherapy (Goodman et al, 2010). This effect can also be seen in adolescents (Cailhol et al, 2013). This is not a problem specific to BPD but found in other mental disorders also (O'Loughlin et al, 2011).

The concept of BPD originated in Western taxonomies (European and then North American). However, even in its definition, it runs into cultural difficulties. For example, the threshold for emotional lability can be different in Latin and Nordic countries; dissociative symptoms are not interpreted in the same way from one continent to the next. So, thresholds set by clinicians for each of the criteria may differ depending on their and their patients' culture. To our knowledge, the symptomatic expression of BPD in adolescence according to culture has barely been explored.

“Borderline patients have long been to psychiatry what psychiatry has been to medicine – a subject of public health significance that is under-recognized, undertreated, underfunded and stigmatized by the larger discipline. As with psychiatry and medicine, this is changing. New knowledge, new attitudes, and new resources promise new hope for persons with borderline personality” (Kernberg & Michels, 2009)

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Through the International Classification of Diseases, the World Health Organisation has promoted the use of this diagnosis throughout the world, in addition to validating an international tool for its diagnosis (Loranger et al, 1994). Nevertheless, the North American model (exemplified by the Diagnostic and Statistical Manual of Mental Disorders, DSM) dominates in research publications (Maffei, 2006). Scientists from different regions of the world continue to use DSM diagnostic criteria as shown by recent publications, which highlights the issue of diagnosis according to culture (Rossier & Rigozzi, 2008; Wong et al, 2010). Migration does not seem to increase the risk of BPD (Pascual et al, 2008).

Burden of illness

It was estimated that BPD costs up to 17,000€ a year per patient in direct and indirect costs in the Netherlands (van Asselt et al, 2007). This includes treatment, particularly hospitalisation, sick leave and loss of productivity. If prevalence in the general population is considered, costs would be substantial. Nevertheless, this European data cannot be extrapolated to the rest of the world as it reflects the medical-economic context in Western countries.

The consequences of BPD for the people around the sufferer depend on their vulnerability to the behaviour and demands of BPD individuals. Families of adolescents in particular need to tackle their child's demands for autonomy whilst protecting the youth and learn to manage worries related to risk-taking behaviour. This can cause considerable stress (Fruzzetti et al, 2005; Gerull et al, 2008; Hoffman et al, 2005).

Apart from physical complications ensuing from self-harming behaviours, BPD patients are exposed to risks due to their impulsivity, resulting mostly in accidents, substance misuse, and sexually transmitted diseases (Sansone et al, 1996, 2000a, 2000b, 2001). Finally, instability in emotional and inter-personal relationships leads to communication problems between parents and children (Guedeney et al, 2008; Hobson et al, 2005, 2009; Newman et al, 2007). Observational studies of mothers with BPD concerning attitudes towards their infants and young children show less availability, poorer organisation of behaviours and mood, and lower expectations of positive interactions. These mothers are described more often as overprotective/intrusive and less as demonstrative/sensitive (Abela et al, 2005; McClellan & Hamilton, 2006; Newman et al, 2007). Their children experience higher rates of parental separation and loss of employment compared to those whose mothers suffer from depression or from other personality disorders.

The psychological development of children with BPD mothers is affected and they tend to withdraw from their surroundings (Abela et al, 2005; McClellan & Hamilton, 2006). These children are less attentive, less interested or eager to interact with their mothers, and demonstrate a more disorganised attachment in the Strange Situation Test (Abela et al, 2005). Children of mothers with BPD show high rates of suicidal thoughts (25%); the risk of children suffering from depression is seven times higher if the mother has a double diagnosis of depression and BPD (Bradley et al, 2005).



The concept of BPD has become part of cultural representations of Western populations: it has emerged in Facebook® and in artistic works (i.e., the book "Borderline" by Marie-Sissi Labrèche, or the film "Girl Interrupted" directed by James Mangold – based on Susanna Kaysen's account of her 18-month stay in a mental hospital).

AGE OF ONSET AND COURSE

DSM-5 recommends that a diagnosis of BPD should not be made before the age of 18 years. In practice diagnosis is made earlier when symptoms are clear and persistent.

Follow up studies show that remission is common – 74% after 6 years; 88% after 10 years (Zanarini et al, 2003a; 2006) – questioning the notion that this is a chronic, unremitting condition. There appears to be two clusters of symptoms, one (characterised by anger and feelings of abandonment) tends to be stable or persistent while the other (characterised by self-harm and suicide attempts) is unstable or less persistent. It should be clarified that in most cases remission actually means a reduction in the number of symptoms below the diagnostic threshold and not necessarily the complete resolution of the disorder (Shea et al, 2002).

The risk of death by suicide in BPD patients is estimated at between 4% and 10%, one of the highest of any psychiatric illness. Suicide risk is higher in the event of co-occurrence with a mood disorder or substance abuse and with increasing number of suicide attempts (Paris, 2002). Suicide seems to occur late in the course of the disorder, around 30-37 years of age, and rarely during treatment (Paris, 2002).

These individuals' functioning is significantly impaired (e.g., Global Assessment of Functioning scale scores around 50), with frequent job losses, unstable relationships, and history of rape (Zittel Conklin & Westen, 2005). Functioning is more impaired than in other personality disorders and depression (Skodol et al, 2002; Zanarini et al, 2005).

Remission is also high when diagnosis is made during adolescence (Bisikin et al, 2011); the peak frequency of BPD symptoms appears to be at 14 years of age (Chabrol et al, 2001b). However, in spite of the high remission rate, the presence of BPD in adolescence is far from harmless. Apart from the already mentioned complications inherent to the disorder, diagnosis increases the risk of other negative outcomes. For example, 80% of teenagers with BPD will suffer from a personality disorder in adulthood, even though BPD will occur in only 16% of them (Deschamps & Vreugdenhil, 2008).

CAUSES AND RISK FACTORS

The cause of BPD is unknown, however, several explanatory hypotheses can be found in the medical literature. The most widely accepted theories are psychogenic, mostly following psychoanalytic thinking. One of the initial explanations was based on the object-relations theory, particularly championed by Otto Kernberg (Clarkin et al, 2006). More recently, John Bowlby's attachment theory provided further insights on the possible mechanisms underlining BPD (Bateman & Fonagy, 2004), while another view emphasizes the importance of emotional dysregulation (Linehan, 1993). Finally, cognitive theories highlight dysfunctional thinking patterns learnt in childhood, which are maintained in adulthood (Young, 1999). All these theories stress the importance of individuals' emotional development, scarred by trauma and emotional deficits, subsequent to a failure to adapt the environment to a child's needs.



Click on the picture to view Emily's history (10:43)



Born in 1926; died in 1962 in tragic circumstances. She was an American actress that became a major sex symbol. She grew up with a mentally unstable mother who was financially unable to care for her. She was two years below the legal age when she married her first husband. She took numerous overdoses and had many passionate relationships. She underwent several psychological treatments and psychiatric hospitalizations.

At an epidemiological level, retrospective research has shown a significant prevalence of childhood trauma, sexual abuse, prolonged separations and neglect among patients with BPD (Zanarini et al, 1997). However, these experiences cannot be construed as direct causes of BPD. Although childhood trauma is high in this population, it is not present in all cases and, when it does exist, it not always causes a BPD. Nevertheless, the high occurrence of early trauma has been used to support an alternative model – as a traumatic disorder resulting from chronic childhood trauma (Golier et al, 2003). Without completely explaining the disorder, repeated childhood trauma seems to be a frequent element in BPD populations and among patients with PTSD. It should be highlighted also that about half the patients with BPD also meet the criteria for PTSD.

Early maternal separation is associated with both BPD and persistence of BPD symptoms over time (Crawford et al, 2009). Finally, BPD also has a genetic component; heritability has been estimated at 47 % (Livesley, 1998). As in almost all psychiatric disorders, inheritance in BPD is polygenic. Further, interaction between genes and environment, as described in the preceding paragraphs, makes it difficult to interpret these data (Steele & Siever, 2010).

DIAGNOSIS

Clinical symptoms

In an effort to improve diagnostic reliability, DSM-III (American Psychiatric Association, 1981) introduced a multi-axial system, placed personality disorders on a different axis, Axis II – alongside intellectual disability – and described BPD as a separate diagnosis. DSM-5 (American Psychiatric Association, 2013)

Table H.4.1 Criteria for and dimensions of borderline personality disorder

	DSM-5 CRITERIA	DIMENSION
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).	Emotional
7 -	Chronic feelings of emptiness	
8 -	Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)	
3 -	Identity disturbance: markedly and persistently unstable self-image or sense of self.	Cognitive
9 -	Transient, stress-related paranoid ideation or severe dissociative symptoms	
4 -	Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating).	Impulsive
5 -	Recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour	
1 -	Frantic efforts to avoid real or imagined abandonment.	Interpersonal
2 -	A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.	

reversed this decision abandoning the multi-axial approach. According to DSM-5, the main characteristics of BPD are instability and impulsivity, as described Table H.4.1. To make a diagnosis of BPD according to DSM-5, the presence of five or more of the symptoms listed in Table H.4.1 is required. Also, the pattern of behaviour must be enduring, inflexible and pervasive across a broad range of personal and social situations, and must cause significant impairment or distress.

The International Classification of Diseases, 10th edition (ICD-10) (World Health Organization, 2000), places BPD within the “emotionally labile personalities” and includes an impulsive sub-type (Table H.4.2). Both classifications require that the behaviour pattern be pervasive, begin in adolescence or early adulthood, and cause significant impairment in functioning.

Subtypes

DSM-5 does not distinguish subtypes within BPD. Subtypes may be defined by the comorbidities. Nevertheless, some researchers propose two subtypes:



Self-cutting is common in people with BPD

Table H.4.2 ICD-10 description of emotionally labile personality**F60.3 Emotionally unstable (borderline) personality disorder**

A personality disorder in which there is a marked tendency to act impulsively without consideration of the consequences, together with affective instability. The ability to plan ahead may be minimal, and outbursts of intense anger may often lead to violence or "behavioural explosions"; these are easily precipitated when impulsive acts are criticized or thwarted by others.

Two variants of this personality disorder are specified, and both share this general theme of impulsiveness and lack of self-control.

Impulsive type:

The predominant characteristics are emotional instability and lack of impulse control. Outbursts of violence or threatening behaviour are common, particularly in response to criticism by others.

Borderline type:

Several of the characteristics of emotional instability are present; in addition, the patient's own self-image, aims, and internal preferences (including sexual) are often unclear or disturbed. There are usually chronic feelings of emptiness. A liability to become involved in intense and unstable relationships may cause repeated emotional crises and may be associated with excessive efforts to avoid abandonment and a series of suicidal threats or acts of self-harm (although these may occur without obvious precipitants).

dependent and *impulsive*. The former would be characterised by ambivalent, unstable relationships; the latter by a pattern of impulsive acts in multiple areas, including breaking the law. ICD-10, on the contrary, describes an impulsive and a borderline subtype (see Table H.4.2).

Presenting symptoms

It is rare for patients to go to see their doctor complaining of BPD, even though publicity about the disorder in the media and Internet has started to make people more aware of this illness. Presentation is often prompted by another problem (i.e., substance misuse, mood swings), problematic behaviour (i.e., abnormal eating, self-harm), or relationship problems. While self-harm decreases over time, it is a particularly useful identifying symptom in adolescence.

From a categorical to a dimensional concept of BPD

If we were to follow the DSM criteria to the letter, BPD would only be diagnosed in adults (Gicquel et al, 2011). However, some clinicians consider that this diagnosis can be made in adolescents with the proviso of accepting a lower predictive power than for adults (Bondurant et al, 2004). Aware of the shortcomings of current taxonomies, there has been a trend towards a dimensional conceptualization of the disorder. Table H.4.1 shows the DSM-5 diagnostic criteria and the four dimensions that have emerged from these criteria.

Within this framework, personality disorders would lie at the extreme end of personality traits, ranging from normal to pathological. Research by Zanarini et al (2007) highlight the stability of the disorder, the average duration of symptoms and the potential for remission and recovery, this is summarised in Table H.4.3.

Table H.4.3 Evolution of borderline personality disorder symptoms over time.

SYMPTOMS	AVERAGE DURATION	
<ul style="list-style-type: none"> • Para-psychotic manifestations • Risky sexual behaviour • Regression linked to treatment • Counter-transference problems, “special” treatment relations 	0 – 2 years	Acute symptoms
<ul style="list-style-type: none"> • Abuse, dependence on psychoactive substances • Self-harm • Repeated suicide attempts • Demandingness • Severe identity disorder 	2 – 4 years	
<ul style="list-style-type: none"> • Stormy relationships • Manipulation, sadism, devaluation • Emotional instability • Unusual perceptual experiences, strange thoughts • Feelings of abandonment, annihilation, collapse • Non hallucinatory paranoid experiences 	4 – 6 years	Temperamental symptoms
<ul style="list-style-type: none"> • Major depressive episode, chronic depression • Chronic feelings of despair, guilt • Chronic anxiety • Overall impulsivity • Cannot bear to be alone • Conflict around dependence on care • Dependency, masochism 	6 – 8 years	
<ul style="list-style-type: none"> • Chronic anger, frequent bouts of anger • Chronic feeling of solitude, emptiness 	8 – 10 years	

It remains to be seen whether some adolescents experience “borderline moments” and others show marginal functioning or organisation. It is a fact that not all marginal adolescents develop BPD. This raises the question of the future of adolescents with marginal functioning. In this line, Bornovalova et al (2009) highlight the risk of diagnostic “labelling” of personality disorders in adolescents, a population undergoing many developmental changes.

DIFFERENTIAL DIAGNOSIS

Comorbidity

An international French-speaking study in adolescents led by the European Research Network on BPD (EURNET-BPD), found that BPD is very often comorbid with depression (71.4%), anorexia (40.2%), bulimia (32.9%), alcohol abuse (23.5%) and substance abuse (8.2%). In particular, comorbid ADHD may be an indicator of severity (Speranza et al, 2011). These data are similar to that reported for adults (Zanarini et al, 1998a). Data from the EURNET-BPD

group found that the highest comorbidity with other personality disorders was for antisocial (22.3%) and avoidant (21.2%), also similar to those found in adults (Zanarini et al, 1998b); there are gender differences in both adolescents and adults with a predominance of comorbid antisocial personality among boys.

Psychometric evaluation

Many instruments exist to evaluate personality disorders in adults. These are some of the most widely used:

- SIDP-IV (Structured Interview for the Diagnosis of DSM-IV Personality Disorders) (Stangl et al, 1985). The DSM-IV version is widely used internationally (Pföhl et al, 1995) and has been used for adolescents (Chabrol et al, 2002)
- SCID-II (Structured Clinical Interview for DSM-IV) (First et al, 1997), complimenting SCID-I, which is used to diagnose Axis I disorders
- The IPDE (International Personality Disorders Examination; (Loranger et al, 1994) is a semi-structured interview that generates personality disorder diagnoses according to both ICD-10 and DSM-IV
- DIB-R (Diagnostic Interview for Borderline-Revised; Zanarini et al, 1990) is a semi-structured interview with 129 items. Although it does not diagnose DSM-IV BPD, it has satisfactory convergent validity with DSM-IV
- CAPA (Child and Adolescent Psychiatric Assessment) may also be relevant for BPD diagnosis (Renou et al, 2004).
- There are also self-report questionnaires that can be useful as screening instruments, such as the MSI-BPD (McLean Screening Instrument for BPD) and the PDQ-4+ (Personality Diagnostic Questionnaire) (Zanarini et al, 2003b, Hyler et al, 1989).

TREATMENT

Several treatment guidelines for BPD are available, i.e., by the American Psychiatric Association (2001) and by the National Institute for Health and Clinical Excellence (NICE, 2009). Most have few recommendations specifically for adolescents.

Aims

Setting a treatment plan and treatment goals is the first step in management, which will be influenced by the patient's instability. In practice, this will entail monitoring the patient's progress, working from a crisis management approach to deal with crises and to manage harmful behaviour, progressing towards long term work on the personality aspects. At each stage a therapeutic contract is set up after needs and reasons for change are determined. Individualised aims would follow a hierarchy that needs to be explained to the adolescent. For example, reducing the risk of death would take precedence over treating symptoms or improving quality of life. Furthermore, adult caregivers need to be involved and assist in management (e.g., by removing toxic substances).

Care framework

Treatment of adolescents with BPD *should usually be delivered as outpatient*. A sequential and eclectic approach offers a pragmatic solution to the clinical diversity and the natural evolution of the disorder (Gunderson, 2001). Determining the care framework thereby involves different aspects:

- Risk evaluation
- Mental state
- Level of psychosocial functioning
- Aims and motivation of the patient
- Social environment
- Comorbidity and
- Predominant symptoms.

In practice, *inpatient treatment* can be considered for cases with severe comorbidity (e.g., addictions, severe depression) and when crisis management or day hospitalisation are unable to contain the patient. The short term management of suicide risk by admission to hospital is undermined by the absence of effectiveness data and the risk of patients' regression.

As outpatient, treatment can be by an individual clinician, as a partnership between a treating psychiatrist and a psychotherapist, or in a day hospital setting, if available. It is helpful if psychotherapy and medication prescription are provided by different clinicians. Finally, the school can also play a role in the management of adolescents with BPD by offering stability and a place where they can build their identity and relationships, essential ingredients for these patients' improvement.

Biological treatments

According to the NICE (2009) guidance, drug treatment should not be used specifically for borderline personality disorder or for the individual symptoms or behaviours associated with the condition (for example, repeated self-harm, marked emotional instability, risk-taking behaviour, and transient psychotic symptoms). However, comorbid disorders may require medication treatment. In addition, side effect profiles, compliance, and the risk of incorrect usage limit the usefulness of medication. Finally, to our knowledge, no drug has been approved for BPD treatment for adults or adolescents. These precautions highlight the limited role of psychotropic drugs in the overall care of BPD.

Apart from expert opinion, several meta-analyses provide guidance (Binks et al, 2006a; Ingenhoven & Duivenvoorden, 2011; Mercer, 2007; Nose et al, 2006; Rinne & Ingenhoven, 2007; Stoffers et al, 2010). The substances studied include neuroleptics, antidepressants, omega-3 fatty acids, and anticonvulsants. However, the short duration of the trials, the low number of studies, the high number of participants lost to follow up, the absence of comparative studies, and restrictive inclusion criteria in most of the controlled trials limit the interpretation of the results.

As far as benzodiazepines are concerned, they can be used in one-off situations but have considerable risk for addiction or for disinhibiting these patients (American Psychiatric Association, 2001). In general, sedative treatments should not be prescribed for more than a week to deal with a crisis (National Institute



Click on the picture to access the NICE guideline



Click on the picture to access the National Health and Medical Research Council of Australia's 2012 Clinical Practice Guideline for the Management of Borderline Personality Disorder. This guideline contains a considerable amount of information about adolescents.

for Health and Clinical Excellence, 2009). This explains the need for intensive monitoring and regular treatment review to identify unhelpful medications and their cautious and gradual removal. Antipsychotic drugs, in particular, should not be used for medium- or long-term treatment (National Institute for Health and Clinical Excellence, 2009). However, in the short-term, antipsychotics can have beneficial effects on cognitive-perceptual symptoms, anger, and mood lability (Ingenhoven & Duivenvoorden, 2011).

Psychotherapy

Psychotherapies used to treat BPD share many aspects. For example, most highlight the importance of drawing a care contract at the start of therapy, including ways of dealing with risk situations, particularly suicidal crises, and contact between sessions (e.g., telephone), which must be agreed upon.

When considering psychological treatment for a person with BPD, clinicians should take into account (National Institute for Health and Clinical Excellence, 2009):

- Patients' choice and preference
- Degree of impairment and severity
- Patients' willingness to engage with therapy and their motivation to change
- Patients' ability to remain within the boundaries of a therapeutic relationship
- The availability of personal and professional support.

A variety of psychotherapy approaches have been used for BPD including individual, group, and crisis treatments. There is no evidence to suggest that one specific form of psychotherapy is more effective than another (Binks et al, 2006b; Leichsenring & Leibing, 2003; Leichsenring et al, 2011).

Schema Focused Therapy (SFT) seeks to extend CBT principles to the treatment of personality disorders by placing greater emphasis on the therapeutic relationship, affect and mood states, lifelong coping styles (e.g., avoidance and overcompensation), entrenched core themes (i.e., maladaptive schemas, which develop when specific, core childhood needs are not met), and more discussion of childhood experiences and developmental processes. One study found that after three years of treatment SFT was more effective than a psychodynamically based transference-focused psychotherapy for participants with BPD (Giesen-Bloo et al, 2006).

Among the group treatments, the **Systems Training for Emotional Predictability and Problem Solving (STEPPS)** (Blum et al, 2002, Blum et al, 2008) is based on a systems approach. The program includes two phases: a 20-week basic skills group, and a one-year, twice-monthly advanced group program. In this model, BPD is understood as a disorder of emotion and behaviour regulation. The goal is to provide the person with BPD, other professionals treating them, and close friends and family with a common language to communicate clearly about the disorder and the skills used to manage it. This helps to avoid "splitting" (a primitive defence mechanism in which the person externalizes internal conflicts by seeking to draw others around them into taking sides or being "good" or "bad").

Tips for treatment

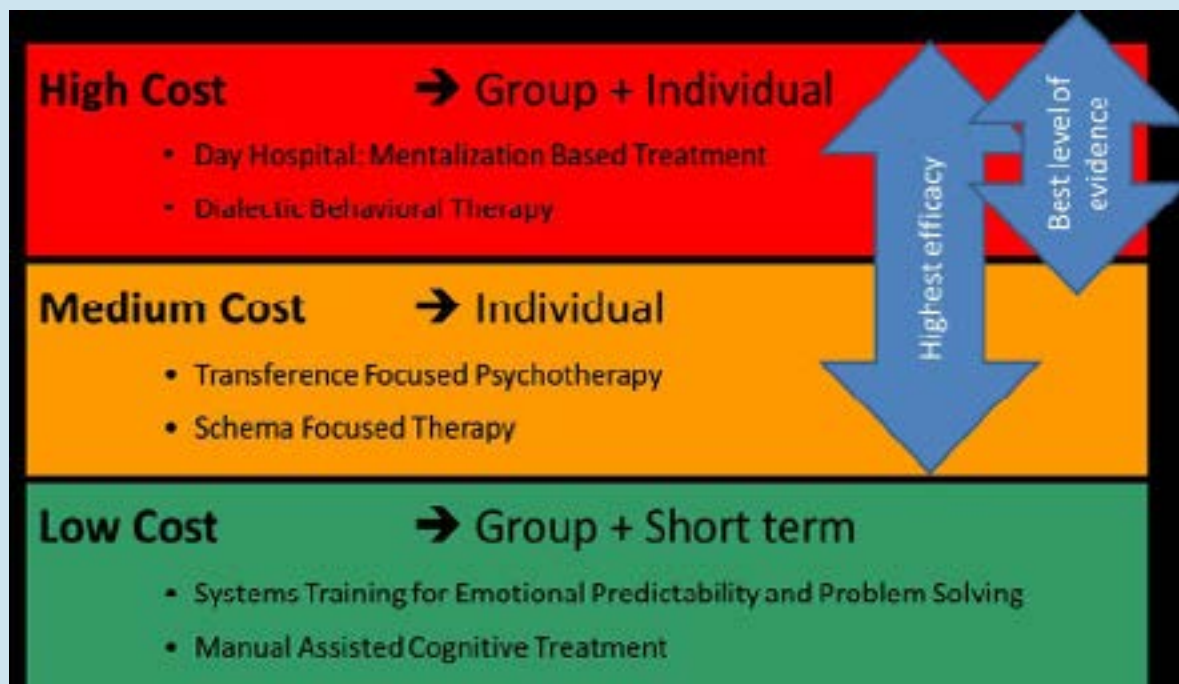
- **Support.** Given the high demands these patients place on clinicians, working in a team makes it easier to manage them. If a team is not available, regular supervision or access to colleagues for advice is highly recommended.
- **Continuity.** Continuity of care over time is essential since treatment usually lasts years rather than weeks or months. Building a therapeutic relationship requires reliability from the professionals providing care.
- **Clear framework.** Both clinician and patients must have a clear understanding of their work, its limits and how they will go about it.
- **Responsibility.** While patients' behaviour and even diagnosis encourage systems (family, therapists, institutions) to take responsibility away from patients, it is useful to remember that increasing their emotional control involves gradually accepting more responsibility.

Mentalization-Based Treatment (MBT)

MBT is a psychodynamic psychotherapeutic program based on attachment theory. It assumes that disorganised attachment promotes a failure in the capacity of mentalization. MBT was first designed for BPD patients. It is currently used for broader indications such as other personality disorders or depression. The treatment consists on group therapy combined with individual therapy, both on a weekly basis, usually in the framework of a day hospital. It aims to enhance the patient's capacity to represent their own and others' feelings accurately in emotionally challenging situations. The main aims of MBT are to improve affect regulation and behavioural control. It allows patients to achieve their life goals and develop more intimate and gratifying relationships.

Unlike in other psychodynamic approaches, the focus is not on transference or past relationships, the aim is not to develop biographical insight but to recover the capacity of mentalization. Therapists seek to promote a secure attachment bond between members of the group and between clients and therapists. This safe attachment provides a relationship context in which to explore one's mind and those of others.

Figure H.4.1: Comparative summary of different psychotherapies for the treatment of borderline personality disorder.





Click on the picture to access a New York Times article on Marsha Linehan's struggle with her BPD and the birth of Dialectical Behavior Therapy

Mentalization Based Treatment (MBT) is a psychodynamic therapy developed by Bateman and Fonagy (1999, 2004). “Mentalization” in this model means the ability to differentiate and separate out one’s own thoughts and feelings from those around us. The various aspects of mentalization are emphasized and are reinforced and practiced within a supportive psychotherapy setting. Because the approach is psychodynamic, therapy tends to be less directive than in CBT.

Transference Focused Psychotherapy (TFP) is another psychodynamic approach. TFP assumes there is a psychological structure that underlies the specific symptoms of BPD. In such a psychological organization, thoughts and feelings about self and others are split into dichotomous experiences of good or bad, black or white, all or nothing. Since these either/or states determine the nature of the patient’s perceptions, splitting leads to chaotic interpersonal relations, impulsive self-destructive behaviours, and other symptoms of BPD. Treatment – consisting of twice weekly individual psychotherapy sessions – focuses on the transference because it is believed that patients live out their predominant object relations dyads in the transference (Clarkin et al, 2007).

In adolescents, **Cognitive Analytic Therapy (CAT)** (Ryle, 2004, Ryle & Beard, 1993) demonstrated similar efficacy to a “manualised good clinical care” treatment (Chanen et al, 2008). The CAT is a relatively brief treatment lasting 16 to 24 sessions.

It remains to be seen whether the gap between the number of treatments and their availability in clinical practice widens or narrows. Lack of support for these treatments at the front line may dishearten clinicians and lead them to ignore or reject psychotherapy options. It is important to remember at this point that a competently delivered treatment – meaning one that adheres to recommendations



Click on the image to access information about mentalisation based therapy

– seems to produce results that are as good as those obtained with more complex treatments (McMain, 2007).

Other treatments

Many teams are working all over the world trying to develop shorter treatments that cost less and are more acceptable to patients than the traditional long term psychotherapeutic ones (see Figure H.4.1). Condensed forms of long-term treatment may be able to offer help to a maximum number of patients. In the same vein, psycho-education and consumer groups may provide valuable alternatives at a lower cost. Setting up a permanent hotline to offer support in difficult times, perhaps at the level of a health region or even a country, may be useful. Finally, prevention services may develop strategies to help parents with a view to reducing the incidence of these disorders in children.

CONCLUSION

BPD is a disorder that can be found in adolescents; it has the range of symptoms and problems found in adults. However, BPD is even more changeable in this age group. A psychotherapeutic approach would result in a reduction of symptoms in many cases. The challenge is to detect the patients that are most at risk of developing severe disorders and offer them the most comprehensive care available.



Click on the picture above to access the TARA website that provides information for sufferers and families (English).

Click on the picture below to access a website that provides information in French.



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