

BORDERLINE PERSONALITY DISORDER IN MEN: COMMON, BUT UNDERDIAGNOSED



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LEARNING OBJECTIVES

- Learning Objective 1: **Contrast Borderline Personality Disorder with Antisocial Personality Disorder**
- Learning Objective 2: **Debate the neurobiologic underpinnings of Borderline Personality Disorder**
- Learning Objective 3: **Express ways in which community paradigms for treatment of BPD can be adapted for correctional settings**
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Review of the criteria of for Borderline Personality Disorder

PHENOMENOLOGICAL DIAGNOSIS

- Based on description of symptom
- Etiology free
- Treatability free

CHANGES BETWEEN DSM 4 AND 5

- Major Changes between DSM IV and DSM 5 were made in approach
- Removal of the Axis System
- Introduction of a new(ish) paradigm for personality disorders
- Based on growing body of evidence of the underlying biologic nature of Personality Disorders.

PERSONALITY DISORDER CRITERIA

An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture. This pattern is manifested in two (or more) of the following areas

- Cognition
- Affectivity
- Interpersonal Functioning
- Impulse Control

PERSONALITY DISORDER CRITERIA CONT'D

- The enduring pattern is inflexible and pervasive across a broad range of social situations.
- The enduring pattern leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- The pattern is stable and of long duration and its onset can be traced back at least to adolescence or early adulthood.
- The enduring pattern is not better explained as a manifestation of another mental disorder.
- The enduring pattern is not attributable to the physiological effects of a substance or another medical condition.

BORDERLINE PERSONALITY DISORDER

- A pervasive pattern of instability of interpersonal relationships, self-image, affect and marked impulsivity, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

I.

- Frantic efforts to avoid real or imagined abandonment

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 (spending, sex, substance abuse, reckless driving, binge eating)

5.

- Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior

6.

- Affective instability due to a marked reactivity of mood

7.

- Chronic feelings of emptiness

8.

- Inappropriate, intense anger or difficult controlling anger

9.

- Transient, stress-related paranoid ideation or severe dissociative symptoms

BORDERLINE PERSONALITY NOTES FROM DSM 5

- BPD Patients engaged in treatment begin to respond within the first year
- During the 30s and 40s patients gain greater stability in their relationships and vocational functioning
- After about 10 years as many as half of the individuals no longer have a pattern of behavior that meets full criteria for borderline personality disorder

BORDERLINE PERSONALITY DISORDER NOTES FROM DSM 5

- BPD is about five times more common among first degree biological relatives of those with the disorder than in the general population
- Increased risk for substance abuse, antisocial personality disorder and depressive disorder or bipolar disorder

BPD PREVALENCE

- Borderline personality disorder (BPD) is common in both the general population and in clinical settings. The point prevalence of BPD is 1.6 percent and the lifetime prevalence is 5.9 percent

BPD PREVALENCE BY GENDER

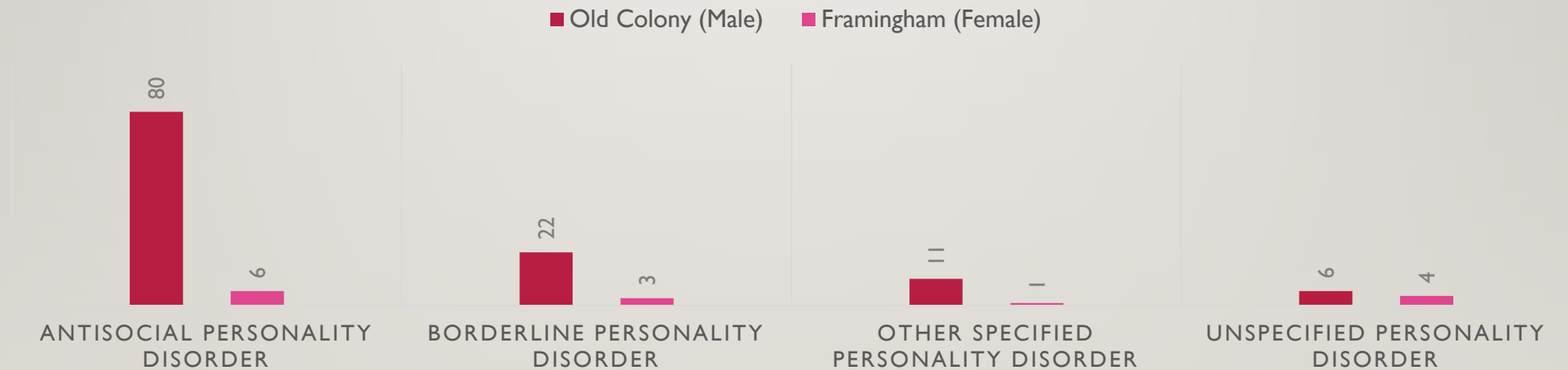
- In clinical populations women have BPD 3X the rate of men
- However in community surveys rates are equal
- Women seek treatment more readily
- Men are misdiagnosed

PREVALENCE OF BPD IN PRISONS

- No good data
- Using ASPD as a proxy number the generally accepted figure is 35%

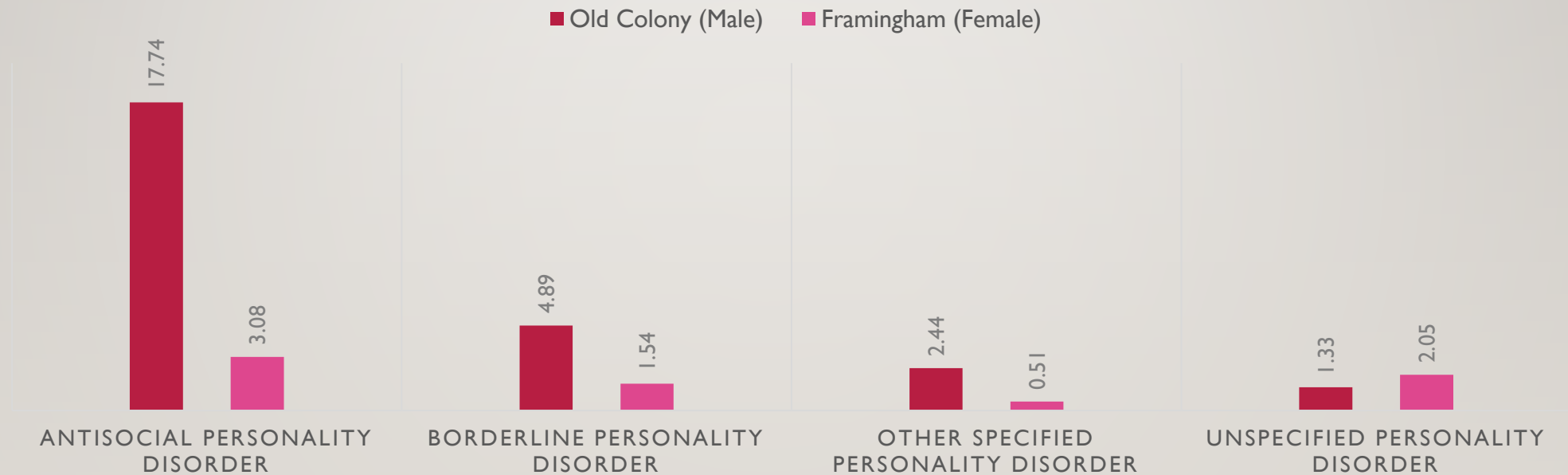
DIAGNOSIS BY NUMBERS; MALE VS FEMALE FACILITY

DIAGNOSIS BY NUMBERS MALE VS FEMALE FACILITY



DIAGNOSIS BY PERCENTAGE OF POPULATION MALE VS FEMALE FACILITY

DIAGNOSIS BY PERCENTAGE OF POPULATION



COMORBIDITY IN BPD

Women and men with BPD have been found to have similar rates of comorbid major depression, but differing rates of other co-occurring psychiatric disorders:

COMORBID CONDITIONS MORE COMMON IN WOMEN WITH BPD

- ● Posttraumatic stress disorder (women versus men, 51 versus 31 percent)
- ● Eating disorder (42 versus 19 percent)
- ● Identity disturbance (67 versus 48 percent)

COMORBID CONDITIONS MORE COMMON IN MEN WITH BPD

- Substance use disorder (women vs men; 58 versus 85 percent)
- ●Antisocial personality disorder (10 versus 30 percent)
- ●Narcissistic personality disorder (5 versus 22 percent)
- ●Schizotypal personality disorder (10 versus 25 percent)

COMORDIBILITY BPD WITH SUDS

- The 2015 and 2016 data from the National Epidemiologic Survey on Alcohol and Related Conditions III [[15,16](#)] indicated significant associations between BPD and Substance use disorders.

GENETIC CONSIDERATIONS BPD

- There is at least moderate evidence for the genetic transmission and heritability of BPD. Two studies found the concordance rate for BPD was higher in monozygotic twins compared with dizygotic twins (35 and 36 percent versus 7 and 19 percent)

GENETICS BPD CONT'D

- In over 2000 Norwegian twins, most of the genetic influence on individual BPD criteria derived from one highly heritable general BPD factor, while environmental influences were mostly criterion specific [[21](#)].

NEUROPSYCHOLOGIC DEFICITS

- Research findings demonstrate widespread neuropsychologic deficits in patient with BPD linked largely to frontal lobe functioning.

THE FRONTAL LOBE CONTROLS IMPULSES



SUMMARY OF STUDIES PRESENTED

- BPD is a mental illness with its own course and symptoms
- Different symptoms may be more prominent in men and women
- In general BPD and all Personality Disorders are Underdiagnosed
- In BPD there is evidence for familial and genetic components and like all mental illnesses the expression is influenced by environmental factors
- Severity of symptoms and morbidity are not static and lifelong as thought in the past and generally improve with time and treatment

MADOC PROGRAMS

- Residential Treatment Units (RTU—four sites)
- Secure Treatment Program (STP)
- Behavior Management Unit (BMU)
- Intensive Treatment Unit (ITU)
- Secure Adjustment Units (SAUs—plan for four units at two sites)
- Behavior Assessment Units (All Medium/Maximum Sites)

FOCUS PROGRAMS

- OCCC RTU: 73 Patients, 8 with BPD (11%)
- SBCC RTU: 23 Patients, 5 with BPD (22%)
- NCCI-Gardner RTU: 24 Patients, 2 with BPD (8%)
- SBCC STP: 17 Patients, 2 with BPD (12%)
- MCI-Cedar Junction BMU: 10 Patients, 3 with BPD (30%)

DIAGNOSTIC THEMES

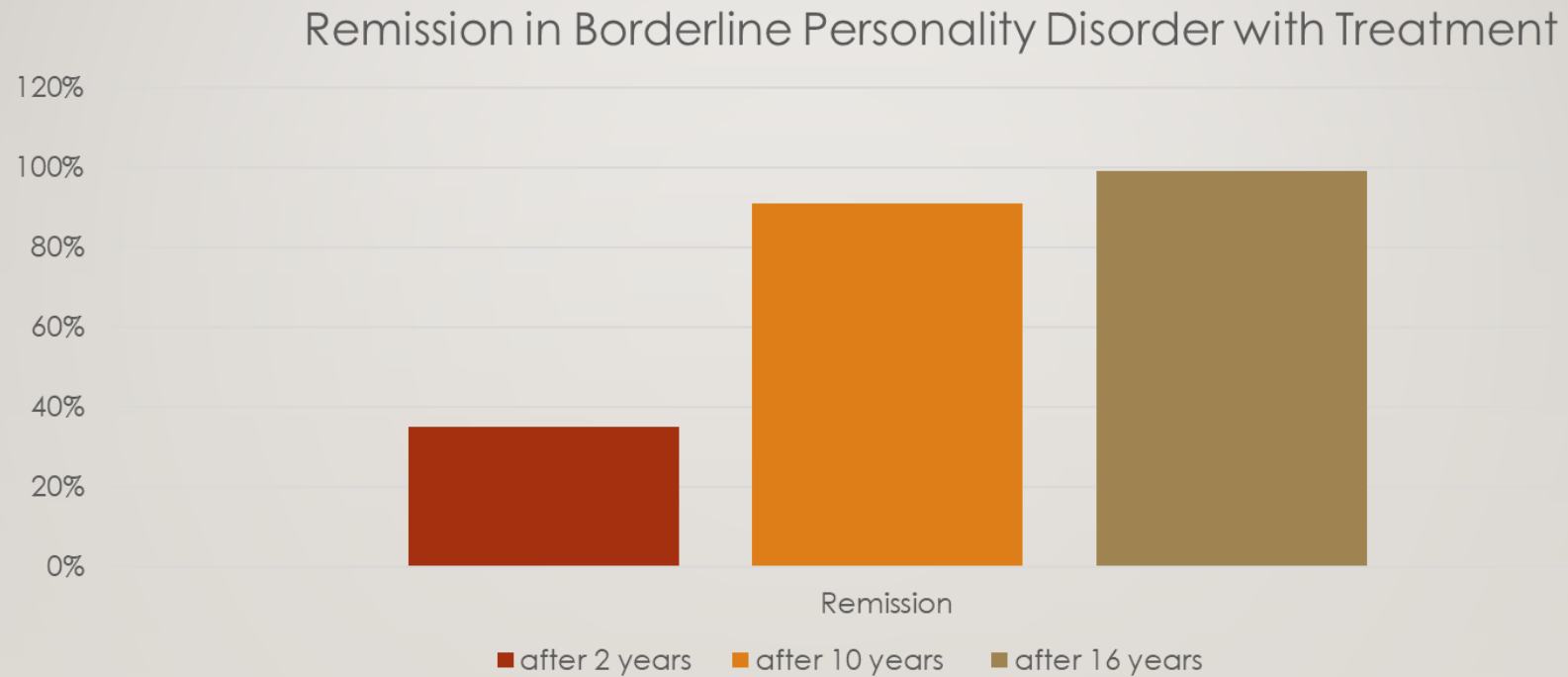
- BPD in 13.6% (not 35%) of RTU and STP/BMU Programs
- Antisocial Personality Disorder More Commonly Diagnosed
- BPD Traits Noted and other Personality Disorder Diagnoses
- Mental Health Teams Continue to Review Patients

COURSE OF ILLNESS BPD

The duration of remission was prolonged for many patients (67). Seventy-eight percent achieved a remission that lasted for at least eight years. Factors associated with a shorter time to remission (65):

- Age 25 or younger (OR 1.46)
- Good functioning at work or school in the two years prior to study (OR 1.61)
- No history of childhood sexual abuse (OR 1.43)
- No history substance abuse (OR 1.40)
- Absence of comorbid anxious cluster Axis II disorder (OR 1.49)
- Low neuroticism (OR 0.97)
- High agreeableness and affiliating tendencies (OR 1.04)

COURSE OF ILLNESS BPD



PSYCHOTHERAPIES TO TREAT PATIENTS WITH BPD

- Dialectical Behavior Therapy (DBT)
- Mentalization-Based Therapy
- Transference-Focused Therapy
- Good Psychiatric Management
- Cognitive-Behavioral Therapy (CBT)
- Systems Training for Emotional Predictability and Problem Solving (STEPPS)

COMMON FACTORS

- Providing an active and focused intervention
- Emphasizing current functioning and relationships
- Targeting affective instability by teaching or helping with emotion regulation
- Targeting impulsivity by helping patients to observe feelings rather than acting on them
- Targeting relationship difficulties by teaching or helping patients to be cognizant of their own feelings and those of other people that is often described as mentalizing or mindfulness
- Improving social cognition dysfunctions by fostering a more coherent identify and enhancing a sense of self-agency and social competence
- Psychoeducation is an essential part of BPD treatment (17) and a specified component of these psychotherapies

DIALECTICAL BEHAVIOR THERAPY

- DBT is a well-studied, evidence-based variation of CBT that includes an emphasis on behaviorally analyzing and managing a hierarchy of treatment targets, including suicidal/dangerous behavior, treatment-interfering behavior, and Quality of Life interfering behavior. It consists of weekly individual psychotherapy with a DBT-trained therapist and group skills training utilizing evidence-based skills and interventions as delineated in the DBT skills manual for approximately one year.

DBT IS A GROUP OF TREATMENTS RATHER THAN ONE TREATMENT

- Diary Cards/Chain Analysis
- Psycho-Education about the diagnosis and what to expect
- Skill-Building including mindfulness, meditation, affect regulation
- Focus on current symptoms, particularly those that emphasize quality of life
- Developing a “life worth living”
- Support for therapists

MENTALIZATION-BASED THERAPY

- Mentalization-based therapy is primarily a psychodynamic therapy that also incorporates cognitive techniques. Patients are taught to observe their state of mind at each moment, and to generate alternative perspectives of subjective experiences of themselves and others.

TRANSFERENCE-FOCUSED THERAPY

- Transference-focused therapy is a psychodynamic psychotherapy that involves exploration, confrontation, and transference interpretations of emotionally charged issues that arise in the relationship between the patient and therapist. The aim is to correct the patient's tendency to perceive significant others in a distorted manner.
- Randomized trials of transference-focused therapy for BPD have found the therapy to be efficacious compared with a control condition but less effective than another psychotherapy developed for BPD.

GOOD PSYCHIATRIC MANAGEMENT

- Diagnostic disclosure and psychoeducation about the disorder
- Active case management with focus upon the patient's life outside of therapy
- Goal-setting and focusing on the best ways to achieve them in order to convey that change is expected
- Focusing on the individual's interpersonal hypersensitivity (e.g., tendency to attach more meaning to trivial interpersonal interactions than warranted) in order to better understand their behavior; teaching how the disorder impacts relationships and how to acquire skills to better manage emotions within those relationships
- Use of multiple treatment modalities (e.g., Alcoholics Anonymous, Narcotics Anonymous) if indicated
- Flexibility with regard to treatment duration and intensity

COGNITIVE-BEHAVIORAL THERAPY

- CBT employs cognitive therapies to address the patient's distorted cognitions about themselves and others, and uses behavioral strategies to improve social and emotional functioning
- Several randomized trials comparing CBT (or cognitive therapies) with a control condition in patients with BPD have found mixed results for primary outcomes, including self-injurious behavior

SYSTEMS TRAINING FOR EMOTIONAL PREDICTABILITY AND PROBLEM-SOLVING

- STEPPS is an effective, CBT-oriented group therapy that includes skills training and family education (29, 33). STEPPS is primarily used as an adjunct to non-CBT-oriented psychotherapies but has also been used adjunctive to DBT.

TEAM PRIORITIES

- Consistent Time
- Consistent Message
- Clear Communication—Patient and Treatment Team
- Use of Positive Language
- Individual and Team Supervision
- Care for Self and Colleagues

QUOTES

- Coordinator Quotes identifying what they have found most helpful in treating patients with BPD.

SUMMARY

- Community studies show that BPD is equal in prevalence in men and women
- In clinical populations and prisons BPD is less often diagnosed in men
- BPD is comorbid with many diagnosis that are common in a prison population including Antisocial Personality Disorder; Substance Use Disorder; Traumatic Brain Injury
- It is important to diagnosis BPD in our populations because there are proven effective treatments for BPD

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