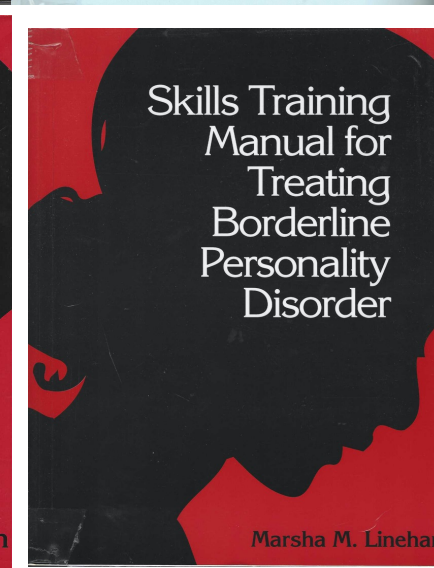
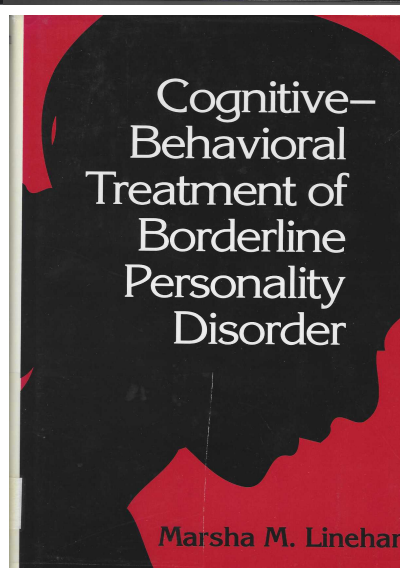
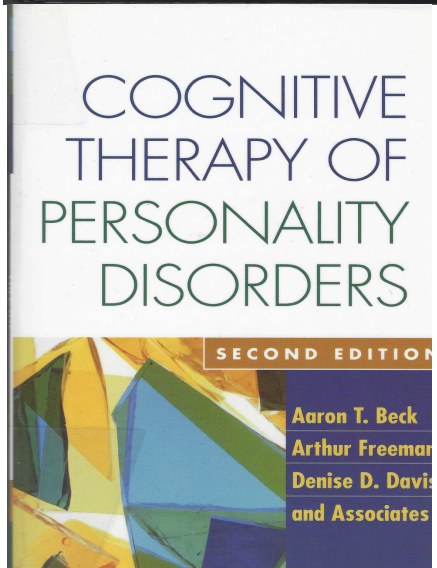
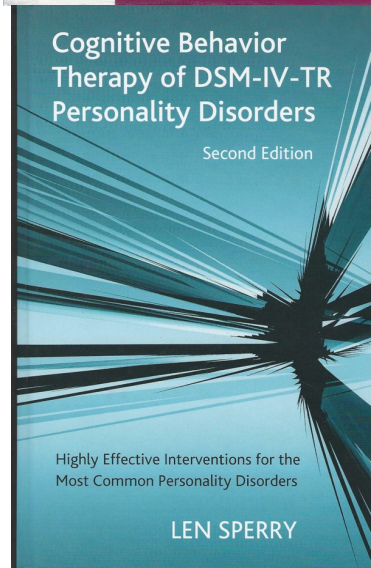
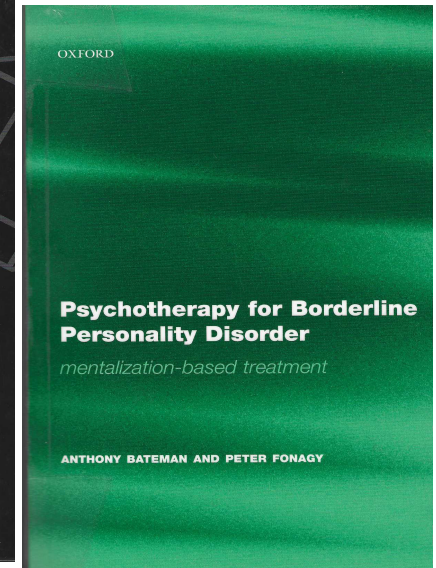
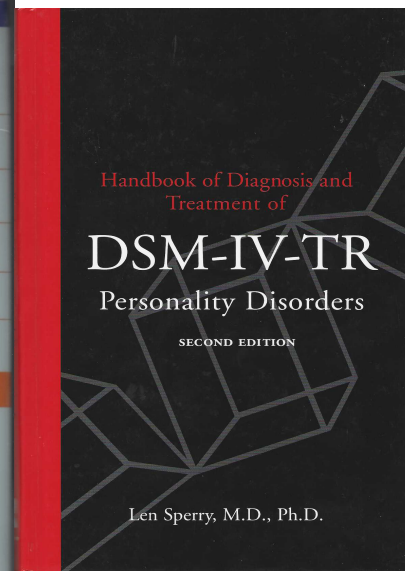
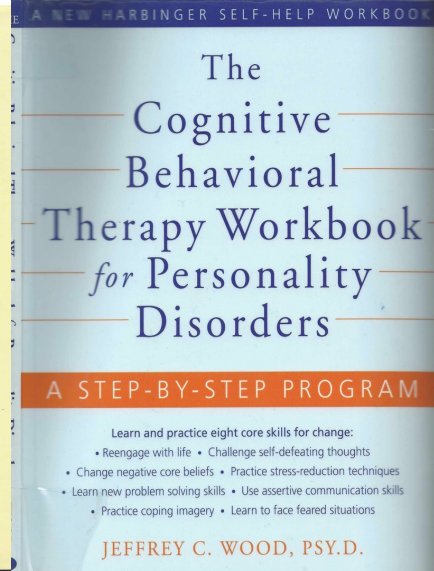
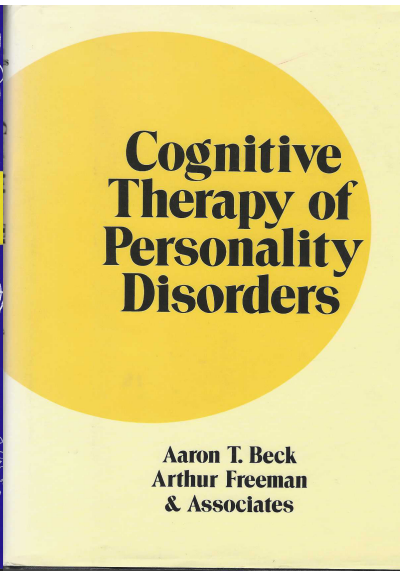
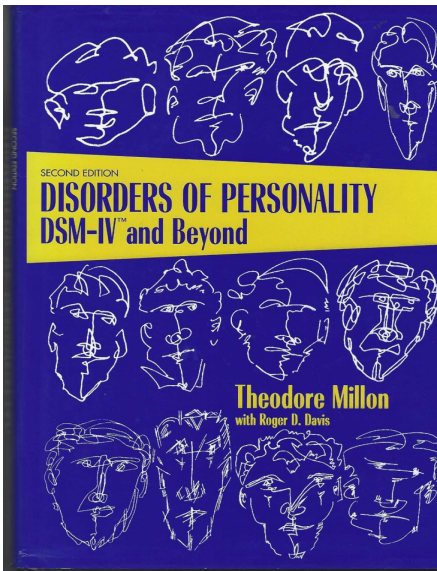
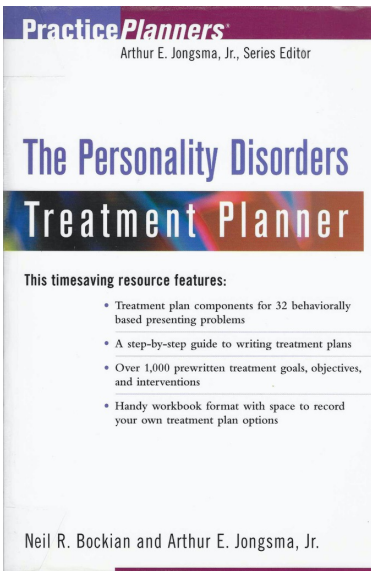


021122 Epävakaat persoonallisuus- esitys Katajapuussa – yl Juha Kemppinen



- Psykiatria-
kirjan uusin
versio
Oppiportissa

021122 Epävakaata persoonallisuus-esitys Katajapuussa

- Agenda:
- 1. Persoonallisuushäiriön yleiset ja erityiset kriteerit: ICD-11 ja DSM-5
- 2. Oirekuva ja diagnostiikka
- 3. Etiologia
- 4. Hoito
- 2010 Oldham et al
https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/bpd-1410197667470.pdf

1. Persoonallisuushäiriön yleiset ja erityiset kriteerit: ICD-11 ja DSM-5

Yl juha kemppinen

- 1
 - Yksilön luonteenomaiset ja pysyvät sisäisen kokemisen tavat ja käytös kokonaisuudessaan poikkeavat merkittävästi kulttuurin sisäisistä normeista.
 - Poikkeama ilmenee vähintään kahdella alla luetellulla alueella:
 - tiedollinen toiminta (kuinka ihminen havaitsee ja tulkitsee asioita, ihmisiä ja tapahtumia miten hän asennoituu ihmisiin ja muodostaa mielikuvia itsestään ja muista)
 - tunne-elämä (tunne-elämän kirjo, voimakkuus ja asianmukaisuus tilanteeseen nähden)
 - impulssikontrolli ja tarpeiden tyydyttäminen
 - ihmissuhteiden luonne ja toimintatapa muiden ihmisten kanssa.
- 2 Poikkeama ilmenee **pysyvänä käytösmallina**, joka on joustamaton, sopeutumaton tai muutoin häiriintynyt laajalti **eri** henkilökohtaisissa ja sosiaalisissa tilanteissa.
- 3 Kohdassa 2 kuvattu käytösmalli **aiheuttaa henkilökohtaista kärsimystä tai vastoinkäymisiä** sosiaalisessa selviytymisessä tai molempia.
- 4 Häiriö on **pysyvä ja pitkäaikainen ja se on alkanut myöhäislapsuudessa tai nuoruusiässä.**
- 5 Häiriö **ei ole** muun aikuispsykiatrisen häiriön ilmenemismuoto tai sen seurausta.
- 6 Elimellinen syy, aivosairaus, -vamma tai toimintahäiriö tulee sulkea pois.

Taulukko 2. Persoonallisuushäiriöt ja pitkäaikaiset persoonallisuuden muutokset (ICD-10).

Persoonallisuushäiriöt

- Epäluuloinen persoonallisuus
- Eristäytyvä, skitsoidinen persoonallisuus
- Epäsosiaalinen persoonallisuus
- Tunne-elämältään epävakaa persoonallisuus**
- Huomionhakuinen persoonallisuus
- Vaativa eli obsessiivis-kompulsiivinen persoonallisuus
- Estynyt persoonallisuus
- Riippuvainen persoonallisuus

Muut määritetyt persoonallisuushäiriöt

Sekamuotoiset ja muut persoonallisuushäiriöt

Pitkäaikaiset persoonallisuuden muutokset, jotka eivät aiheudu aivovauriosta tai aivosairaudesta

- Tuhoisaa kokemusta seuraava persoonallisuuden muutos
- Vakavaa mielenterveyden häiriötä seuraava pitkäaikainen persoonallisuuden muutos
- Muut määritetyt pitkäaikaiset persoonallisuuden muutokset

Taulukko 3. DSM-5-luokituksen mukaiset persoonallisuushäiriöt.

Ryhmä A

Epäluuloinen persoonallisuushäiriö

Eristäytyvä persoonallisuushäiriö

Psykoosi- tai psykoosipiirteinen persoonallisuushäiriö

Ryhmä B

Epäsosiaalinen persoonallisuushäiriö

Epävakaa persoonallisuushäiriö

Huomiohakuinen persoonallisuushäiriö

Narsistinen persoonallisuushäiriö

Ryhmä C

Estynyt persoonallisuushäiriö

Riippuvainen persoonallisuushäiriö

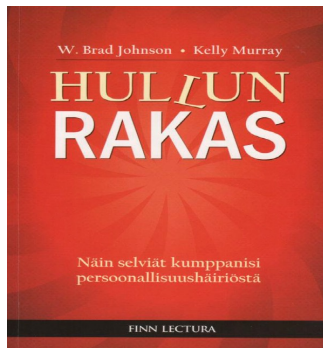
Pakko-oireinen persoonallisuushäiriö

TABLE 16.2. Assessing Personality Disorder in Mental Health Patients

1. In general, do you have difficulty making and keeping friends?	ystävystyminen
2. Would you normally describe yourself as a loner?	yksinäisyys
3. In general, do you trust other people?	luottamus
4. Do you normally lose your temper easily?	maltti
5. Are you normally an impulsive sort of person?	impulsiivinen
6. Are you normally a worrier?	huolehtija
7. In general, do you depend on others a lot?	riippuvainen
8. In general, are you a perfectionist?	täydellisyyden- tavoittelija

Note. From “Standardised Assessment of Personality—Abbreviated Scale (SAPAS): Preliminary Validation of a Brief Screen for Personality Disorder” by Paul Moran, Morven Leese, Tennyson Lee, Paul Walters, Graham Thornicroft, and Anthony Mann, 2003, *British Journal of Psychiatry*, 183, 228–232. Copyright 2003 by the Royal College of Psychiatrists. Reprinted by permission.

Morrison 2005



MYRSKYISÄ KUMPPANI

Epävakaa persoonallisuus

Kuinka tunnistaa epävakaa persoonallisuus

- ✓ Hän pelkää äärimmäisen paljon hylkäystä, ja usein tulkitsee käytösesi torjuvaksi.
- ✓ Hänellä on ollut useita kiihkeitä, epävakaita ja ailahtelevia suhteita.
- ✓ Hänellä on hyvin hauras minäkäsitys.
- ✓ Hänellä on taustalla impulsiivista käytöstä (esim. äkillistä rahan tuhlausta, seksiä, aineiden käyttöä, holtitonta ajamista, ahmimista).
- ✓ Hän on käyttäytynyt itsetuhoisesti tai viillellyt itseään.
- ✓ Hänellä on voimakkaita mielialanvaihteluita (esim. masennuksen, ahdistuksen ja suuttumuksen välillä).
- ✓ Hän tuntee jatkuvasti olonsa "tyhjäksi" ja tylsistyneeksi.
- ✓ Hän saattaa suuttua asiaankuulumattomasti ja hyökätä verbaalisesti tai fyysisesti.

- Persoonallisuushäiriöiden dimensionaalinen arviointi: ICD-11 ja DSM-5
- ICD-11
- Persoonallisuushäiriölle on luonteenomaista pitkään, esimerkiksi **kaksi vuotta tai pitempään** kestäneet ongelmat minän toiminnoissa ja/tai ihmissuhteissa.
- **Minän toimintoja** ovat muun muassa **identiteetti, itsen arvostus, minäkäsitys, ja itseohjautuvuus. Ihmissuhteita** kuvastavat kyky luoda ja ylläpitää läheisiä ja molemmin puolin tyydyttäviä ihmissuhteita, kyky ymmärtää toisten näkökulmia ja selviytyä ihmissuhderistiriidoista.
- Häiriö näkyy myös **kognitiivisten toimintojen, emotionaalisten kokemusten, tunteiden ilmaisan ja käyttäytymisen maladaptiivisuutena eli joustamattomuutena ja hallitsemattomuutena.** Häiriö tulee esiin useissa eri yksilöllisissä ja sosiaalisissa tilanteissa. Henkilölle luonteenomaiset käyttäytymismallit eivät ole kehityksellisesti asianmukaisia, eivätkä ne selity kulttuurisilla tekijöillä.
- Persoonallisuushäiriö aiheuttaa asianomaiselle **merkittävää kärsimystä tai toimintakyvyn heikkenemistä** henkilökohtaisessa elämässä. Kärsimys ja toimintakyvyn heikkeneminen ilmenee myös **perhe-elämässä, sosiaalisissa suhteissa, opiskelussa, työssä** tai joillakin muilla tärkeillä elämänalueilla.
- ICD-11 ryhmittelee persoonallisuushäiriön **lieväksi, keskivaikeaksi tai vaikeaksi** sen perusteella, miten vakavia ja laaja-alaisia edellä kuvatut ongelmat ovat ja miten vakavaa kärsimystä ja haittaa ne aiheuttavat.

Persoonallisuuspiirteistä häiriöksi – klinikon näkökulma

TAULUKKO 3.

Persoonallisuushäiriöiden luokittelu ICD-11 tautiluokituksen luonnoksessa (21).

Potilaalla, jolla todetaan persoonallisuushäiriön yleisten kriteerien täyttyvän, luokitellaan persoonallisuushäiriön vaikeusaste aluksi kolmeasteisella luokittelulla. Häiriön ydinpiirteitä voidaan kuvata tarkemmin dimensionaalisten piirreluokkien avulla.

Persoonallisuushäiriön aste	Kuvaus	Piirreluokat	Tyypilliset piirteet
Lievä persoonallisuushäiriö	Persoonallisuuden vaikeudet aiheuttavat merkittäviä ongelmia ihmissuhteissa ja elämän eri osa-alueilla, mutta toimivat joissakin suhteissa ja osa-alueilla. Häiriö ei tyypillisesti aiheuta merkittävää haittaa itselle tai muille.	Negatiivinen emotionaalisuus Epäsosiaaliset piirteet	Kokee herkästi esim. ahdistuneisuutta, masentuneisuutta, vihaisuutta ja itseinhoa. Piittaamattomuus sosiaalisista velvoitteista, yhteiskunnan normeista ja muiden tunteista. Esimerkiksi tunnekylmyys, vihamielisyys ja pyrkimys hyväksikäyttää muita luonnehtivat.
Kohtalainen persoonallisuushäiriö	Merkittäviä ongelmia useimmissa ihmissuhteissa ja elämän eri osa-alueilla. Tyypillisesti itseä tai muita vahingoittavaa käytöstä, mutta ei suoraan henkeä uhkaavaa (esim. itsetuhoista käytöstä ilman varsinaista itsemurhatarkoitusta).	Kyvyttömyys/haluttomuus hallita impulsseja Pakonomaisuus/vaativuus	Toimii impulsiivisesti ja harkitsematta tekojensa seurauksia. Vastuuttomuus, impulsiivisuus ja harkitsemattomuus luonnehtivat. On hyvin jäykkä siinä, minkälaista käyttäytymistä hyväksyy itseltään ja muilta. Piirteistä vaativuus, jääräpäisyys ja järjestelmällisyys luonnehtivat.
Vaikea persoonallisuushäiriö	Ongelmat ihmissuhteissa ja elämän eri osa-alueilla ovat laaja-alaisia ja merkittäviä. Häiriö aiheuttaa tai on aiheuttanut henkeä uhkaavaa tai pitkäaikaista vahinkoa itselle tai muille.	Irrallisuus/välinpitämättömyys	Vetäytyy ihmissuhteista ja suhtautuu välinpitämättömästi sosiaalisiin kontakteihin ja ihmissuhteisiin. Varautuneisuus, passiivisuus ja niukka tunneilmaisu luonnehtivat.

- Persoonallisuushäiriöiden dimensionaalinen arviointi:
- ICD-11 ja DSM-5
- ICD-11
- Lisäksi persoonallisuushäiriön diagnoosiin kuuluu, että siinä kuvataan aina **yhtä tai useampaa kuudesta piirreominaisuudesta, jotka kuvaavat henkilön persoonallisuutta**. Nämä piirreominaisuudet ovat
- **negatiivinen affektisuus** (*negative affectivity*)
- **eristäytyvyys** (*detachment*)
- **dissosiaalisuus** (*dissociality*)
- **impulsiivisuus** (*disinhibition*)
- **pakko-oireisuus** (*anankastia*)
- **epävakaus** (*borderline pattern*).

- **DSM-5**
- Järjestelmä sisältää vaihtoehtoisen tavan luokitella persoonallisuushäiriöitä (***alternative DSM-5 model for personality disorders, AMPD***), joka yhdistää dimensionaalisen ja kategoriaalisen arviointitavan.
- Luokituksessa arvioidaan persoonallisuuden toimintaa ja patologisia persoonallisuuden piirteitä. Persoonallisuuden toiminnan arviossa kiinnitetään huomio minätoimintoihin ja vuorovaikutussuhteisiin.
- **Minätoiminnoissa** arvioidaan identiteettiä ja itseohjautuvuutta, **vuorovaikutussuhteissa** empatiaa ja kykyä läheisyyteen.
- Näitä arvioidaan jatkumolla luokitukseen sisältyvän arviointiasteikon (*level of personality functioning scale, LPFS*) avulla. Jotta persoonallisuushäiriödiagnoosi voidaan asettaa, näiden toimintojen tulee olla **vähintään keskivaikeasti häiriintyneitä.**

- **DSM-5**
- Poikkeavia persoonallisuuden piirteitä arvioidaan **viidellä** laajalla alueella:
- **negatiivinen affektisuus vs. emotionaalinen vakaus**
- **vetäytyminen vs. ulospäin suuntautuneisuus**
- **antagonismi vs. sovittelevuus**
- **disinhibiitio vs. vastuullisuus**
- **psykoosipiirteisyys vs. selkeys.**
- Häiriöiden arvioitavilla alueilla tulee olla suhteellisen laaja-alaisia ja pysyviä.
- Luokituksessa on **kuusi persoonallisuushäiriötä**: antisosiaalinen, estynyt, epävakaa, narsistinen, pakko-oireinen ja psykoosipiirteinen persoonallisuushäiriö.
- Jos henkilö täyttää persoonallisuushäiriön **yleiset kriteerit**, mutta häiriö ei ole luokiteltavissa johonkin edellä mainituista kuudesta häiriöstä kuuluvaksi, määritetään **häiriö siinä esiintyvien hallitsevien persoonallisuuspiirteiden** mukaan.

Taulukko 1. Persoonallisuushäiriöiden piirteet ja esiintyvyys (Volkert ym, 2018).

Persoonallisuushäiriö	Tyypillisiä piirteitä	Esiintyvyys
Epäluuloinen persoonallisuus	Epäluuloisuus Herkkyys vastoinikäymisille Kyvyttömyys antaa anteeksi loukkauksia Taipumus kokemusten vääristymiseen	3,0 % (1,1–5,3 %) Miehillä yleisempi
Eristäytyvä persoonallisuus	Vetäytyminen sosiaalisista suhteista, erakoituminen Yksinäiset harrastukset, Rajoittunut tunneilmaisu Rajoittunut kyky kokea mielihyvää	2,8 % (0,6–6,6 %) Miehillä yleisempi
Epäsosiaalinen persoonallisuus	Piittaamattomuus sosiaalisista velvollisuuksista ja normeista Välinpitämättömyys toisten tunteista Alhainen turhaumien sietokyky Taipumus moittia muita selkkauksista normien kanssa Taipumus toistuvaan rikollisuuteen	3,1 % (2,1–4, 2 %) Miehillä yleisempi

Taulukko 1. Persoonallisuushäiriöiden piirteet ja esiintyvyys (Volkert ym, 2018).

Persoonallisuushäiriö	Tyypillisiä piirteitä	Esiintyvyys
Tunne-elämältään epävakaa persoonallisuus	Tunne-elämän epävakaus Taipumus toimia hetken mielihohteesta Ennalta arvaamaton mielialan vaihtelu Hallitsemattomat tunteenpurkaukset Taipumus riitaisuuteen	1,9 % (0,9–3,3 %) Naisilla yleisempi
Huomionhakuinen persoonallisuus	Tarve olla huomion keskipisteenä olemalla eloisa, dramaattinen, flirttaileva Taipumus liioitella ihmissuhteidensa läheisyyttä tai intiimiyttä Suurieleinen, teennäinen esiintyminen	0,8 % (0,4–1,5 %) Ei sukupuolieroa
Narsistinen persoonallisuus	Suuruusmielikuvien sävyttämä kuva itsestä ja omasta tärkeydestä Omien kykyjen yliarviointi Muiden vähättely ja hyväksikäyttö Odottaa tulevansa kohdelluksi ainutlaatuisena, ylivertaisena Kyky aitoon myötätuntoon heikentynyt	1,2 % (0,4 - 2,4 %) Miehillä yleisempi

Taulukko 1. Persoonallisuushäiriöiden piirteet ja esiintyvyys (Volkert ym, 2018).

Persoonallisuushäiriö	Tyypillisiä piirteitä	Esiintyvyys
Vaativa persoonallisuus	Täydellisyyden tavoittelu Liiallinen tunnollisuus Pikkutarkkuus, huolellisuus, kontrolloivuus Joustamattomuus, itsepäisyys	4,3 % (2,2–7,2 %) Miehillä yleisempi
Estynyt persoonallisuus	Jännityksen, pelon, epävarmuuden, alemmuuden tunteet Hyväksynnän, kiintymyksen tarve Yliherkkyys hylkäämiselle ja arvostelulle	2,8 % (1,7–4,1 %) Ei sukupuolieroa
Riippuvainen persoonallisuus	Laaja-alainen, alistuva tukeutuminen toisiin Voimakas hylätyksi tulemisen pelko Avuttomuuden ja kyvyttömyyden tunne Alistuva mukautuminen muiden toiveisiin Heikko kyky vastata arjen vaatimuksiin	0,8 % (0,4–1,4 %) Ei sukupuolieroa

2. Oirekuva ja diagnostiikka

Yl juha kemppinen

Tunne-elämältään epävakaa persoonallisuushäiriö

- Oirekuva ja diagnostiikka
- Tunne-elämältään epävakaaaseen persoonallisuushäiriöön liittyy kolme oirekokonaisuutta: **tunne-elämän epävakaus, käyttäytymisen säätelyn häiriö sekä alttius ongelmiin vuorovaikutussuhteissa.**
- Häiriöstä kärsiville on ominaista **taipumus toimia hetken mielijohteesta ja harkitsematta seurauksia.**
- Henkilön **mieliala on ennustamattomasti vaihteleva ja oikukas.**
- Hän on **taipuvainen tunteenpurkauksiin eikä** kykene usein **hallitsemaan** purkauksellista käytöstään.
- Henkilö on myös taipuvainen **riitaisuuteen ja yhteentörmäyksiin toisten kanssa**, varsinkin kun hänen mielijohteita noudattavaa käytöstään estetään tai hillitään.

Tunne-elämältään epävakaa persoonallisuushäiriö

- **Oirekuva ja diagnostiikka**
- Tautiluokitus jakaa häiriön impulsiiviseen ja rajatilatyyppiin (taulukko [1](#)).
- **Impulsiivisessa** häiriötyypissä **tunne-elämän epävakaus ja yllykkeitten hallinnan puute** ovat luonteen omaisia. Väkivaltaiset purkaukset ja uhkaava käytös ovat tavallisia, etenkin reaktiona muiden kritiikkiin.
- **Rajatilatyyppiä** puolestaan luonnehtii **tunne-elämän epävakaus**. Sille ovat ominaisia **häiriöt minäkuvassa, päämäärien asettamisessa ja sisäisissä pyrkimyksissä** sekä jatkuva tyhjyyden tunne.
- **Kiihkeät ja epävakaat ihmissuhteet** saattavat aiheuttaa toistuvasti tunne-elämän kriisejä. Ne voivat olla yhteydessä liialliseen pyrkimykseen välttää hylätyksi tulemistä. Nämä kriisit voivat johtaa **toistuvaan itsetuhoisuuteen**.
- Epävakasta persoonallisuushäiriöstä kärsivällä henkilöllä on taipumus **jännitystä ulospäin purkavaan ja toisiin ihmisiin vetoavaan käyttäytymiseen**.

Tunne-elämältään epävakaa persoonallisuushäiriö

- Oirekuva ja diagnostiikka
- Oirekuvaan voi liittyä myös stressitilanteissa ilmeneviä **ajoittaisia, lyhytkestoisia, psykoottisilta** vaikuttavia oireita, **epäluuloisia ajatusrakennelmia** tai **vakavia dissosiatiivisia oireita**, kuten voimakkaita depersonalisaatioelämyksiä.
- Muut samanaikaiset mielenterveyshäiriöt ovat yleisiä epävakasta persoonallisuushäiriöstä kärsivillä. Yleisimpiä ovat mieliala- ja päihdehäiriöt. **Lähes 10 % epävakasta persoonallisuushäiriöstä kärsivistä sairastaa elämänsä aikana psykoottisen häiriön.**
- Epävakaan persoonallisuushäiriön prevalenssiksi väestössä on arvioitu **1–2 %**. Potilasaineistoissa häiriö on huomattavasti yleisempi. Perusterveydenhuollon potilailla sen yleisyydeksi on arvioitu noin 6 %, psykiatrisilla avohoitopotilailla noin 25 %. **Hoitoon tulevista persoonallisuushäiriöpotilaista noin puolella on epävakaa persoonallisuushäiriö.**

Taulukko 1. Tunne-elämältään epävakaa persoonallisuushäiriö (ICD-10).

Impulsiivinen häiriötyyppi

A. Täyttää persoonallisuushäiriön yleiset kriteerit.

B. Kohta (2) ja sen lisäksi vähintään kaksi seuraavista:

- (1) taipumus toimia hetken mielijohteesta ja seurauksia harkitsematta
- (2) taipumus käyttäytyä riitaisasti ja joutua ristiriitatilanteisiin muiden ihmisten kanssa etenkin, jos impulsiivista käytöstä pyritään estämään tai sitä arvostellaan
- (3) alttius vihan ja väkivallan purkauksille ja kyvyttömyys hallita niitä
- (4) kyvyttömyys ylläpitää mitään toimintaa, joka ei tuota välitöntä palkkiota
- (5) epävakaa ja oikukas mieliala.

Rajatilatyyppe

A. Täyttää persoonallisuushäiriön yleiset kriteerit.

B. Diagnoosin F60.30 osiosta B. esiintyy vähintään kolme ja lisäksi ainakin kaksi seuraavista:

- (1) minäkuvan, sisäisten pyrkimysten ja seksuaalisen suuntautuneisuuden epävarmuus ja häiriintyneisyys
- (2) taipumus intensiivisiin ja epävakaisiin ihmissuhteisiin ja niiden myötä tunne-elämän kriiseihin
- (3) liiallinen hylätyksi tulemisen välttäminen
- (4) toistuvaa itsensä vahingoittamista tai sillä uhkailua
- (5) jatkuva tyhjyyden tunne.

Epävakaa Persoonallisuus (Borderline Personality Disorders)

= Laaja-alaista ihmissuhteisiin, minäkuvaan ja affekteihin liittyvää epävakautta ja huomattavaa impulsiivisuutta. Alkaa varhaislapsuudessa ja esiintyy monissa yhteyksissä >5 seuraavista tavoista :

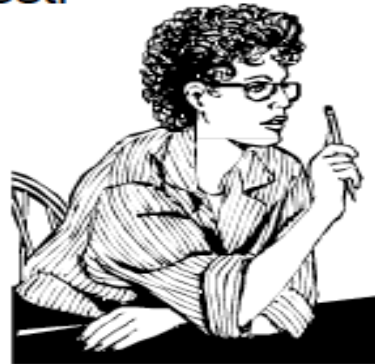
1. Kiihkeitä yrityksiä välttää todelliselta tai kuvitellulta hyljätyksi tulemiselta

2. Epävakaita ja intensiivisiä ihmishuhteita, joita luonnehtii äärimmäisen ihannoinnin ja vähättelyn vaihtelu (joko yksi pitkä tai useampia lyhyitä huhteita, joihin on liittynyt väh kahdesti ihannoinnin tai vähättelyn vaihtelu)

3. Identiteettihäiriö, merkittävästi ja jatkuvasti epävakaa minäkuva tai kokemus itsestä, ei normaali nuoruusikäisen epävarmuus (myöntää piirteen)

4. Impulsiivisuus >2 potentiaalisesti itselle vahingollisella alueella: tuhlaaminen, seksi, päihteiden käyttö, holtiton autoilu, ahminen (us esim jotkaa viittaavat impulsiiviseen käyttäytymiseen, jotka eivät välttämättä rajoitu em:hin)

***Diagnoosi :
vähintään 5
kriteeriä
täyttyy***



5. Toistuva itsetuhoinen käytös, siihen viittaavat eleet tai uhkaukset tai itsensä viiltely ym. vahingoittaminen (>2 tapausta muulloin kuin vakavan masennuksen aikana)

6. Affektiivinen epävakaus, joka johtuu mielialan merkittävästä reaktiivisuudesta (esim. intensiivinen jaksottainen dysforia, ärtyneisyys tai ahdistuneisuus, joka tavallisesti kestää muutamia tunteja ja vain harvoin muutamaa päivää kauemmin) (myöntää piirteen)

7. Krooniset tyhjyyden tuntemukset (myöntää piirteen)

8. Asiaankuulumaton, voimakas suuttumus vaikeus kontrolloida suuttumusta (esim toistuva äkkipikaisuus, jatkuva vihaisuus, toistuva tappeleminen) (myöntää piirteen ja väh 1 esim)

9. Ohimenevä, stressiin liittyvä paranoidinen ajattelu tai vakava dissosiativinen oireilu (us esim, jotka eivät esiinny vain psykoottisen häiriön tai psykoottisen mielialahäiriön aikana)

8.6.05 juha kemppinen

Table 7.4 Capricious/Borderline Personality Disorder Subtypes

Discouraged: Pliant, submissive, loyal, humble; feels vulnerable and in constant jeopardy; feels hopeless, depressed, helpless, and powerless. (Mixed Borderline/Avoidant-Depressive-Dependent Subtype)

Self-Destructive: Inward-turning, intropunitively angry; conforming, deferential, and ingratiating behaviors have deteriorated; increasingly high-strung and moody; possible suicide. (Mixed Borderline/Depressive-Negativistic Subtype)

Impulsive: Capricious, superficial, flighty, distractible, frenetic, and seductive; fearing loss, becomes agitated and then gloomy and irritable; potentially suicidal. (Mixed Borderline/Histrionic-Antisocial Subtype)

Petulant: Negativistic, impatient, restless, as well as stubborn, defiant, sullen, pessimistic, and resentful; easily slighted and quickly disillusioned. (Mixed Borderline/Negativistic Subtype)

Table 7.2 Self-Perpetuating Processes: Capricious/Borderline Personality

Countering Separation

- Insinuates self into lives of others
- Demeans self to gain empathic attention
- Repeatedly reverses coping strategies

Releasing Tensions

- Externalizes inner fright and torment
- Sulking expresses anger and retaliation
- Moping makes others feel guilty

Redemption through Self-Derogation

- Resentments may provoke abandonment threats
- Reproaches self to achieve expiation
- Castigates self to justify worthless feelings

Lunastus itseään vähättelemällä

Moittii itseään saadakseen sovituksen

Soimaa itseään...

TABLE 1.3. Behavioral Patterns in BPD

1. *Emotional vulnerability*: A pattern of pervasive difficulties in regulating negative emotions, including high sensitivity to negative emotional stimuli, high emotional intensity, and slow return to emotional baseline, as well as awareness and experience of emotional vulnerability. May include a tendency to blame the social environment for unrealistic expectations and demands.
2. *Self-invalidation*: Tendency to invalidate or fail to recognize one's own emotional responses, thoughts, beliefs, and behaviors. Unrealistically high standards and expectations for self. May include intense shame, self-hate, and self-directed anger.
3. *Unrelenting crises*: Pattern of frequent, stressful, negative environmental events, disruptions, and roadblocks—some caused by the individual's dysfunctional lifestyle, others by an inadequate social milieu, and many by fate or chance.
4. *Inhibited grieving*: Tendency to inhibit and overcontrol negative emotional responses, especially those associated with grief and loss, including sadness, anger, guilt, shame, anxiety, and panic.
5. *Active passivity*: Tendency to passive interpersonal problem-solving style, involving failure to engage actively in solving of own life problems, often together with active attempts to solicit problem solving from others in the environment; learned helplessness, hopelessness.
6. *Apparent competence*: Tendency for the individual to appear deceptively more competent than she actually is; usually due to failure of competencies to generalize across expected moods, situations, and time, and to failure to display adequate nonverbal cues of emotional distress.

BORDERLINE

BEHAVIORAL DEFINITION

1. Makes desperate attempts to avoid abandonment.
2. Has unstable and intense relationships, usually involving alternately idealizing and denigrating another person.
3. Sense of self or self-image is chronically unstable.
4. Acts on impulse in ways that can be self-damaging (e.g., overspending, sex, drugs).
5. Makes frequent suicidal gestures or threats or mutilates himself/herself.
6. Has highly unstable moods (e.g., gets depressed, irritable, or anxious for brief periods).
7. Chronically experiences feelings of emptiness.
8. Is easily provoked to anger or rage.
9. Under stress, can become paranoid or experience dissociative symptoms.

BORDERLINE—PETULANT

BEHAVIORAL DEFINITION

1. Is generally negativistic, sullen, pessimistic, and easily disillusioned.
2. Tends to be impatient and restless.
3. Is stubborn and defiant and has difficulty with authority figures.
4. Has deep, ambivalent feelings about connecting to others, fears losing independence, and dreads isolation and abandonment.
5. Is hypersensitive to criticism and easily feels slighted.
6. Is prone to brief, transient psychotic episodes, especially with mood-dominated features (e.g., delusions of worthlessness).
7. Is prone to suicidal gestures and behaviors.

BORDERLINE—SELF-DESTRUCTIVE

BEHAVIORAL DEFINITIONS

1. Has punitive feelings (anger and guilt) toward self.
2. Feels hopeless, helpless, and powerless.
3. Has history of conforming, deferential, and ingratiating behavioral pattern.
4. Makes frequent suicidal gestures or threats or mutilates himself/herself.
5. Is high-strung, moody, and easily angered toward others.
6. Is hypervigilant and fearful.
7. Is hypersensitive to any distorted perception of being abandoned.

Borderline Symptom List 23 (BSL-23)

Code: _____

Date: _____

Please follow these instructions when answering the questionnaire: In the following table you will find a set of difficulties and problems which possibly describe you. Please work through the questionnaire and decide how much you suffered from each problem in the course of the last week. In case you have no feelings at all at the present moment, please answer according to how you *think you might have felt*. Please answer honestly. **All questions refer to the last week. If you felt different ways at different times in the week, give a rating for how things were for you on average.**

Please be sure to answer each question.

In the course of last week...		not at all	a little	rather	much	very strong
1	It was hard for me to concentrate	0	1	2	3	4
2	I felt helpless	0	1	2	3	4
3	I was absent-minded and unable to remember what I was actually doing	0	1	2	3	4
4	I felt disgust	0	1	2	3	4
5	I thought of hurting myself	0	1	2	3	4
6	I didn't trust other people	0	1	2	3	4
7	I didn't believe in my right to live	0	1	2	3	4
8	I was lonely	0	1	2	3	4
9	I experienced stressful inner tension	0	1	2	3	4
10	I had images that I was very much afraid of	0	1	2	3	4
11	I hated myself	0	1	2	3	4
12	I wanted to punish myself	0	1	2	3	4
13	I suffered from shame	0	1	2	3	4
14	My mood rapidly cycled in terms of anxiety, anger, and depression	0	1	2	3	4
15	I suffered from voices and noises from inside or outside my head	0	1	2	3	4
16	Criticism had a devastating effect on me	0	1	2	3	4
17	I felt vulnerable	0	1	2	3	4
18	The idea of death had a certain fascination for me	0	1	2	3	4
19	Everything seemed senseless to me	0	1	2	3	4
20	I was afraid of losing control	0	1	2	3	4
21	I felt disgusted by myself	0	1	2	3	4
22	I felt as if I was far away from myself	0	1	2	3	4
23	I felt worthless	0	1	2	3	4

Borderline symptom list 23 (BSL-23)

Now we would like to know in addition the quality of your **overall** personal state in the course of the last week. 0% means **absolutely down**, 100% means **excellent**. Please check the percentage which comes closest.

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
(very bad)										(excellent)

BSL - Supplement: Items for Assessing Behavior

During the last week.....		Not at all	once	2-3 times	4-6 times	Daily or more often
1	I hurt myself by cutting, burning, strangling, headbanging etc.	0	1	2	3	4
2	I told other people that I was going to kill myself	0	1	2	3	4
3	I tried to commit suicide	0	1	2	3	4
4	I had episodes of binge eating	0	1	2	3	4
5	I induced vomiting	0	1	2	3	4
6	I displayed high-risk behavior by knowingly driving too fast, running around on the roofs of high buildings, balancing on bridges, etc.	0	1	2	3	4
7	I got drunk	0	1	2	3	4
8	I took drugs	0	1	2	3	4
9	I took medication that had not been prescribed or if had been prescribed, I took more than the prescribed dose	0	1	2	3	4
10	I had outbreaks of uncontrolled anger or physically attacked others	0	1	2	3	4
11	I had uncontrollable sexual encounters of which I was later ashamed or which made me angry.	0	1	2	3	4

Please double-check for missing answers

WE THANK YOU VERY MUCH FOR YOUR PARTICIPATION!
PLEASE RETURN THE QUESTIONNAIRE TO YOUR THERAPIST

TABLE 9.2

Possible Indications of Borderline Personality Disorder

In Presenting Problems and Symptoms:

1. A diverse assortment of problems and symptoms, which may shift from week to week
2. Unusual symptoms or unusual combinations of symptoms
3. Intense emotional reactions that are out of proportion to the situation
4. Self-punitive or self-destructive behavior
5. Impulsive, poorly planned behavior that is later recognized as foolish, "crazy," or counterproductive
6. Brief periods of psychotic symptoms that meet DSM-III-R criteria for brief reactive psychosis (but that may have been misdiagnosed as schizophrenia)
7. Confusion regarding goals, priorities, feelings, sexual orientation, etc.
8. Feelings of emptiness or void, possibly localized in the solar plexus

In Interpersonal Relationships:

1. Lack of stable intimate relationships (possibly masked by stable nonintimate relationships or relationships that are stable as long as full intimacy is not possible)
2. Tendency to either idealize or denigrate others, perhaps switching abruptly from idealization to denigration
3. A tendency to confuse intimacy and sexuality

In Therapy:

1. Frequent crises, frequent telephone calls to the therapist, or demands for special treatment in scheduling sessions, making final arrangements, etc.
2. Extreme or frequent misinterpretations of therapist's statements, intentions, or feelings
3. Unusually strong reactions to changes in appointment time, room changes, vacations, or termination of therapy
4. Low tolerance for direct eye contact, physical contact, or close proximity
5. Unusually strong ambivalence on many issues
6. Fear of change or unusually strong resistance to change

In Psychological Testing:

1. Good performance on structured tests such as the WAIS, combined with poor performance or indications of thought disorder on projective tests
2. Elevation of both "neurotic" and "psychotic" MMPI scales (2, 4, 6, 7, 8) or indications of an unusually wide variety of problems

3. Etiologia

Yl juha kemppinen

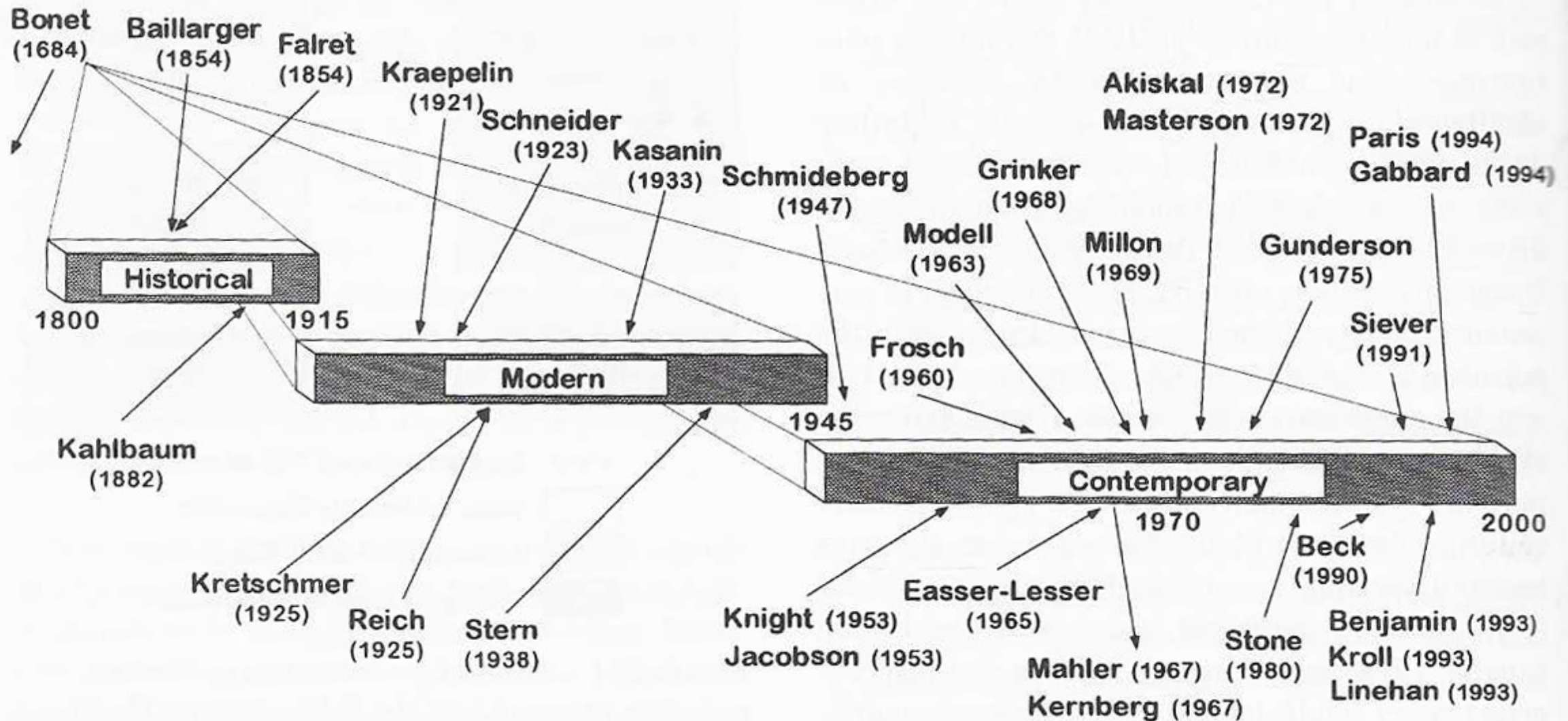


Figure 18.2 Historical review of major contributors to the borderline personality disorder.

- **Etiologia**

- Epävakaan persoonallisuushäiriön keskeisenä etiologisena tekijänä pidetään varhaista lapsen ja vanhempien suhdetta, joka on johtanut **erillistymis-yksilöitymiskehityksen häiriöön**.
- **Lapsuudenaikainen tunnetason laiminlyönti ja puutteellinen tuki, varhaiset menetyskokemukset, seksuaalinen hyväksikäyttö ja vanhempien vakavat mielenterveyshäiriöt** ovat tavallisia epävakaasta persoonallisuudesta kärsivien elämänhistoriassa.
- Biologisista tekijöistä ainakin häiriöt **aivojen frontolimbisillä alueilla** ovat ilmeisesti yhteydessä epävakaassa persoonallisuudessa yleisesti esiintyviin impulsiivisiin ja vihamielisiin piirteisiin.
- Osalla potilaista persoonallisuushäiriön synty liittyy **neurologisiin ja neurokognitiivisiin häiriöihin ja niiden kehityksellisiin vaikutuksiin**.

- Etiologia
- Psykodynaamisessa tarkastelussa rajatilapersoonallisuus tai kehityksellisesti rajatilatasoinen häiriö ovat laajempia käsitteitä kuin ICD-10-luokituksen diagnoosi epävakaa persoonallisuushäiriö.
- Rajatilatasoisilla häiriöillä tarkoitetaan häiriöitä, jotka ovat **kehityksellisesti varhaisempia ja vaikeampia** kuin neuroottistasoiset tilat, mutta lievempiä kuin psykoosit. Käytännöllisesti katsoen lähes kaikki persoonallisuushäiriöt ovat psykodynaamisesti arvioituina rajatilatasoisia häiriöitä.
- Rajatilatasoisella häiriöllä voidaan tarkoittaa myös sellaisia häiriöitä, joissa persoonallisuushäiriöiden kuvailevat oirekriteerit eivät täyty.
- Psykodynaamisen kehitysarvion mukaan niissä voidaan kuitenkin havaita niin sanottua rajatilapatologiaa, johon kuuluvat **vakava itsetunnon säätelyn häiriö, kyvyttömyys erottaa itseä ja toisia koskevia mielikuvia, epäkypsien puolustusmekanismien voimakas käyttö, huono pettymyksensietokyky ja puutteellinen väkivaltaisuuden kontrollointi.**

4. Hoito

Yl juha kemppinen

Pers.häiriö Suurin kl.piiirre Kognitio Affekti Käyttäyt. Ihmissuhteet

Klusteri B *Epävakaa persoonallisuus (Borderline)*
(dramaattinen, emotionaalinen, arvaamaton)



Epä-
vakaa

Impulsiivi-
suus

Hylätyksi
tulemisen
odotus, itsen
ja muiden yli-
ja aliarvioinnin
vaihtelu

Impulsiivi-
suus, aggres-
siivisuus,
masennus

Taistelee
toisten kanssa,
itsen vahingoit-
taminen

Useita
suhteita,
joissa
hätäänty-
neitä
yrityksiä
välttää
hylkäys

Pers.häiriö Kokemus sairaudesta Ongelmallinen käytt. Hoitostrategia

Vastaan-
otolla BPD:
epävakaisuus
vuorovaikutus-
suhteissa,
omakuvassa
ja affekteissa,
huomattava
impulsiivisuus

Pelottavat
mielikuvat
sairaudesta

Chapter 7.
The Borderline
Personality



Pelko torjumisesta
ja hylkäämisestä,
itsetuhoiset teot,
hoitavan henkilön
ihailun ja
aliarvioinnin
vaihtelu

Vältä liiallista tutta-
vallisuutta
Ohjelmoi säännölliset
vierailuajat
Tarjoa selviä, ei-teknisiä
selityksiä
Siedä vihanpurkauksia,
mutta aseta rajat
Ylläpidä tietoisuutta
henkilökohtaisista
tunteista
Konsultoi psykiatria

- Hoito
- Epävakaasta persoonallisuushäiriöstä kärsivien **hoito on vaativaa** sekä potilaalle että hoitaville henkilöille. Potilaat ovat usein **regressiivisiä, impulsiivisia ja ajelehtivia**.
- Hoitosuhteissa ajaututaan helposti **monimutkaiseen vuorovaikutusongelmiin** varsinkin silloin, jos hoitavalla henkilöllä ei ole riittävää koulutusta tai työnohjausta.
- Potilaan hoito **tulee toteuttaa pääsääntöisesti avohoidossa**, mutta häiriöön liittyvät **kriisivaiheet** voivat edellyttää **sairaalahoidoa**, erityisesti jos potilaalla on **itsetuhoista käyttäytymistä** tai persoonallisuushäiriöoireiden kanssa samanaikaisia **psykoottisia tai vakavia mielialaoireita**.

- Hoito
- Potilaan oireilun ja toimintakyvyn **pitkäaikaisarviointi** on keskeistä sen tunnistamisessa, mikä on sellaista akuuttia hätää, joka on sairaalahoidon peruste.
- Päivystystilanteissa tällainen arviointi ei ole useinkaan helppoa, mutta **mahdollisimman monipuolinen tiedonkeruu potilasasiakirjoista ja potilaan tuntevia haastatteleminen** edistävät arvion osuvuutta.
- Potilaan **itsetuhokäyttämisen riskitekijöiden arviointi** (luku [«Itsetuhokäyttäytyminen»](#)) on tärkeää.
- Potilaan hoidon koordinoimiseksi on hyödyllistä **nimetä vastuhenkilö ja vastuutyöryhmä**.
- Potilaan **hoidon tavoitteet** sekä avohoidolle että mahdollisille sairaalahoitajaksoille **suunnitellaan selkeästi**.

This plan is to be agreed by all members of treatment team.

Mr Anthony Challenge experiences regular episodes of (Insert self-harm, suicide attempt, dangerous behaviour, etc). This is a result of his personality difficulties.

He has been assessed by (Insert Name) and the following crisis plan developed with him:

1. He will report indicators of forthcoming crisis by contacting (Insert Name and Telephone Number).
2. If (Insert name) is unavailable Mr A Challenge will contact (insert office administrator Name and number) who will inform another member of team.
3. The team aim to respond within X hours during normal working hours or before 10 am on the next working day.
4. Known factors include: (Insert List e.g. alcohol, increase in drug use, feelings of rejection, and interpersonal difficulties).
5. If contact is made during normal working hours (Insert Name) the crisis will be discussed over the phone initially.
6. If resolution is problematic or risk considered high, a brief appointment will be made to decide on further action including in-patient admission, referral to medical services.
7. The crisis, once resolved, will be discussed in detail in the next clinical sessions.
8. No change in overall treatment plan will be made during a crisis and there will be no change in medication without discussion with the team.
9. **Out of hours** Mr Anthony Challenge will contact (Insert Emergency Details). They will listen to the problems, assess risk but not alter or prescribe

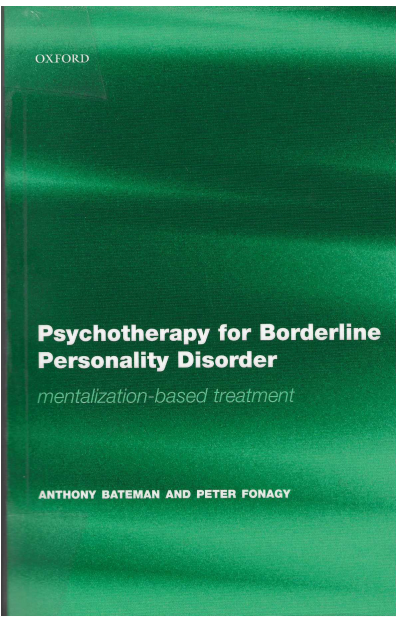
medication, and offer appropriate intervention until a member of treatment team can be contacted on the following working day.

Signed:

Patient:

Key worker:

Agreed by team : Yes ☐ No ☐

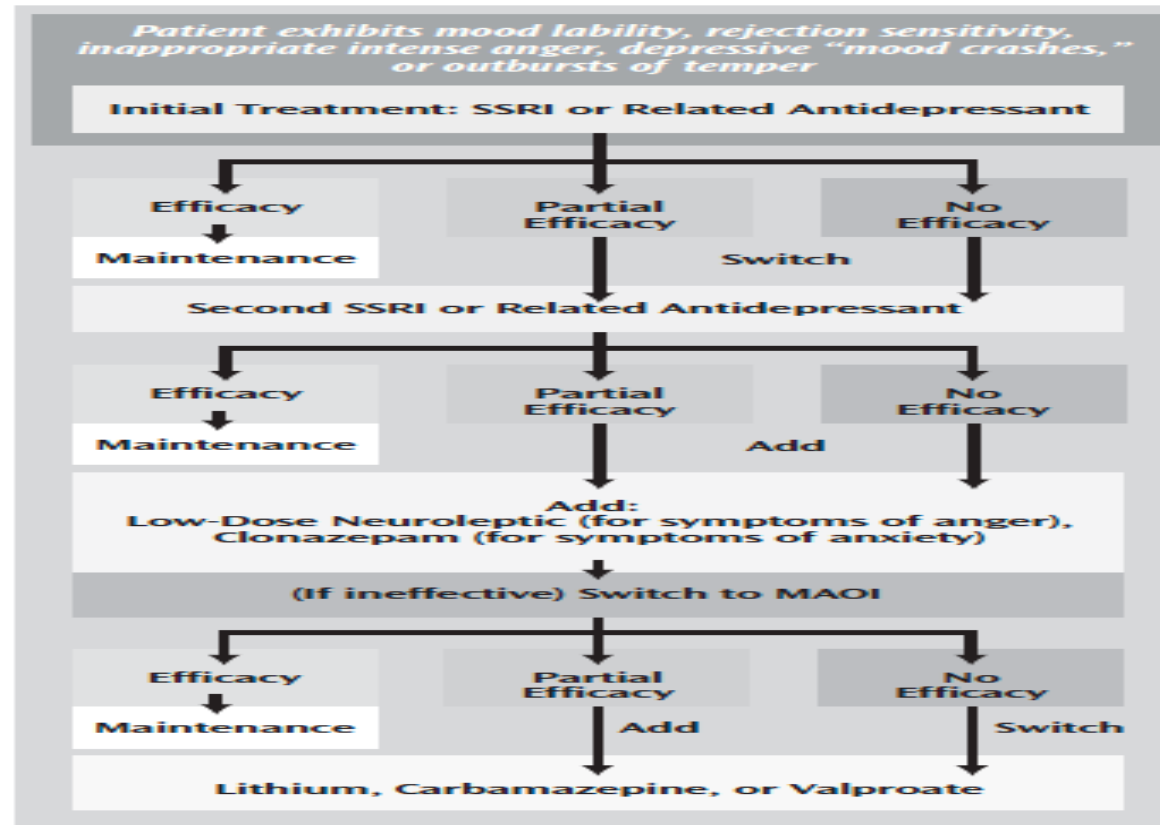


- Psykoterapia
- Psykoterapeuttiset hoitomenetelmät ovat hoidossa keskeisiä. Epävakaasta persoonallisuushäiriöstä kärsiville on kehitetty **kognitiivis-behavioraalisen** psykoterapian muotoja, joihin sisältyy vuorovaikutuksellista ymmärtämistä ja vuorovaikutustaitojen harjoittelua.
- Vahvin tutkimusnäyttö on **dialektisesta käyttäytymisterapiasta** epävakaasta persoonallisuushäiriöstä kärsivien persoonallisuushäiriöoireiden vakavuuden, päihteiden käytön, itsen vahingoittamisen ja itsemurhayritysten sekä psykiatrisen sairaalahoidon tarpeen vähentämisessä.
- Psykodynaamisista terapioiden **mentalisaatioterapia** soveltuu hyvin epävakaan persoonallisuushäiriön hoidoksi. Myös **transferenssikeskeinen psykoterapia ja skeematerapia** ovat epävakaan persoonallisuushäiriön näyttöön perustuvia hoitoja.
- Psykoterapian onnistuminen edellyttää usein sitä, että psykoterapeutti saa säännöllistä **työnohjausta** ja että **moniammatillinen työryhmä** osallistuu potilaan kokonaishoitoon hyvin suunnitellulla tavalla.

- **Psyykenlääkehoito**
- Psykoosilääkkeet **saattavat lievittää** pieninä annoksina epävakaaseen persoonallisuushäiriöön liittyvää **vihamielisyyttä, epäluuloisuutta, tunnesäätelyn häiriöitä, psykoottisia oireita ja tahallista itsen vahingoittamista**. On harkittava, mitä etuja ja haittoja psykoosilääkkeiden käytöllä on silloin, kun potilaalla ei ole varsinaisia psykoottisia oireita.
- **Mielialaa tasaavista lääkkeistä** voi olla hyötyä impulsiivisuuden ja aggressiivisuuden vähentämisessä. **SSRI-lääkkeistä** voidaan käyttää depression ja muiden samanaikaisten häiriöiden kuten ahdistuneisuuden, mielialan vaihteluiden, vihamielisyyden, ärtyneisyyden, impulsiivisuuden ja itsetuhoisuuden hoidossa.
- **Bentsodiatsepiineja ei suositella epävakaan persoonallisuushäiriön hoidossa.**
- Epävakaan persoonallisuushäiriön lääkehoidon tulisi nojautua **selkeään hoitosuunnitelmaan**, johon kuuluu säännöllinen hoitovasteen arviointi.

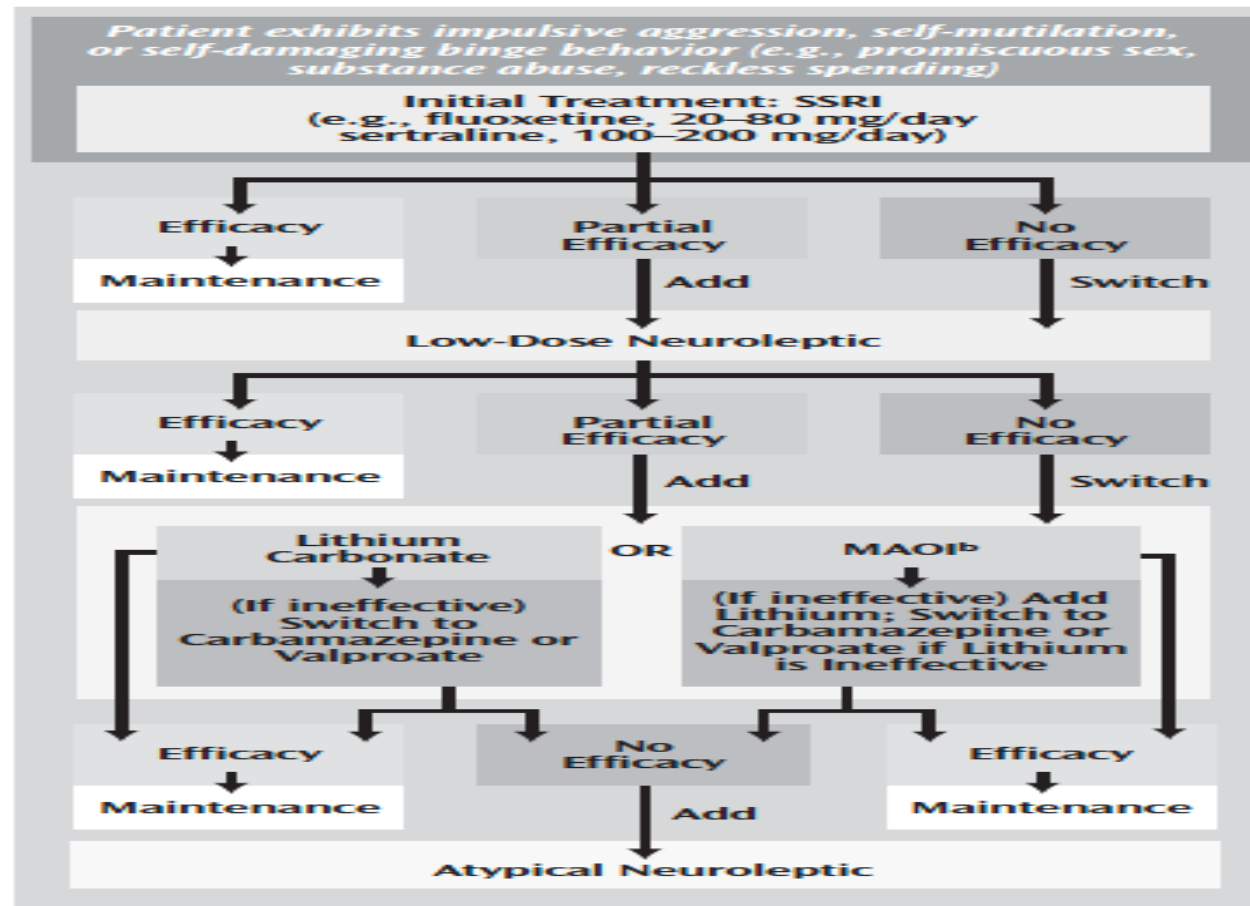
PSYCHOPHARMACOLOGICAL TREATMENT ALGORITHMS

APPENDIX 1 PSYCHOPHARMACOLOGICAL TREATMENT OF AFFECTIVE DYSREGULATION SYMPTOMS IN PATIENTS WITH BORDERLINE PERSONALITY DISORDER^a.



^aAlgorithm based on clinical judgment that uses evidence currently in the literature, following the format of the International Psychopharmacology Algorithm Project (2). The first step in the algorithm is generally supported by the best empirical evidence. Recommendations may not be applicable to all patients or take individual needs into account. The empirical research studies on which these recommendations are based may be "first trials" involving previously untreated patients and may not take into account previous patient nonresponse to one, two, or even three levels of the algorithm (i.e., patients who, by definition, have more refractory disorders). There are no empirical trials of the complete algorithm.

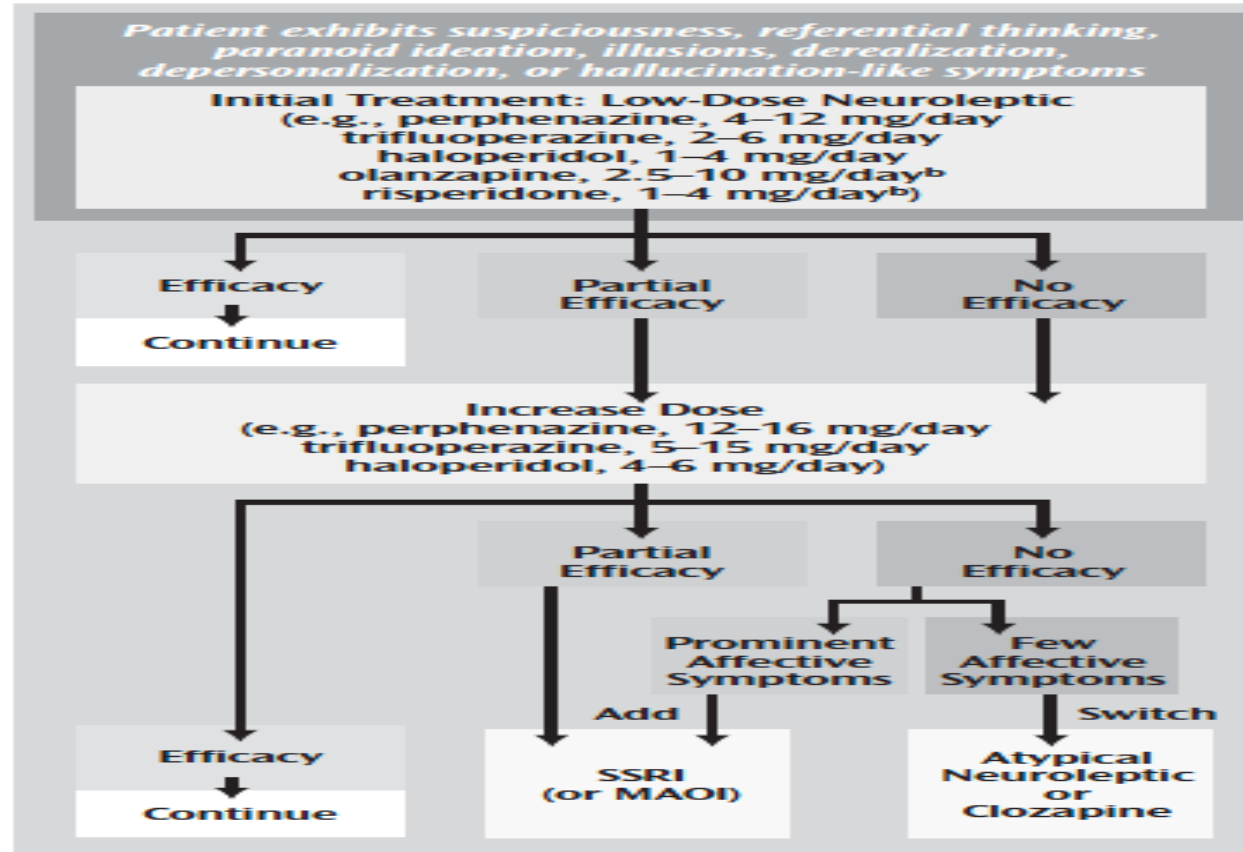
PSYCHOPHARMACOLOGICAL TREATMENT OF IMPULSIVE-BEHAVIORAL DYSCONTROL SYMPTOMS IN PATIENTS WITH BORDERLINE PERSONALITY DISORDER^a.



^aAlgorithm based on clinical judgment that uses evidence currently in the literature, following the format of the International Psychopharmacology Algorithm Project (2). The first step in the algorithm is generally supported by the best empirical evidence. Recommendations may not be applicable to all patients or take individual needs into account. The empirical research studies on which these recommendations are based may be “first trials” involving previously untreated patients and may not take into account previous patient nonresponse to one, two, or even three levels of the algorithm (i.e., patients who, by definition, have more refractory disorders). There are no empirical trials of the complete algorithm.

^bSSRI treatment must be discontinued and followed with an adequate washout period before initiating treatment with an MAOI.

PSYCHOPHARMACOLOGICAL TREATMENT OF COGNITIVE-PERCEPTUAL SYMPTOMS IN PATIENTS WITH BORDERLINE PERSONALITY DISORDER^a.



^aAlgorithm based on clinical judgment that uses evidence currently in the literature, following the format of the International Psychopharmacology Algorithm Project (2). The first step in the algorithm is generally supported by the best empirical evidence. Recommendations may not be applicable to all patients or take individual needs into account. The empirical research studies on which these recommendations are based may be “first trials” involving previously untreated patients and may not take into account previous patient nonresponse to one, two, or even three levels of the algorithm (i.e., patients who, by definition, have more refractory disorders). There are no empirical trials of the complete algorithm.

^bThe generally favorable side effect profiles of the newer atypical neuroleptic medications compared with those of conventional neuroleptics underscore the need for careful empirical trials of these newer medications in the treatment of patients with borderline personality disorder.

TABLE 2. Psychopharmacological Treatment Recommendations for Affective Dysregulation Symptoms in Patients With Borderline Personality Disorder

Drug Class	Specific Medications Studied	Symptoms for Which Medication Is Recommended	Strength of Evidence ^a	Issues
SSRIs and related antidepressants	Fluoxetine, sertraline, venlafaxine ^b	Depressed mood, mood lability, rejection sensitivity, anxiety, impulsivity, self-mutilation, anger/hostility, psychoticism, and poor global functioning	A	Relatively safe in overdose; favorable side effect profile; evidence obtained from acute (6–14 weeks), continuation (up to 12 months), and maintenance (1–3 years) treatment trials; second SSRI trial may still be effective if first trial fails (“salvage strategy,” strength of evidence=C)
MAOIs	Phenelzine, tranylcypromine	Mood reactivity, rejection sensitivity, impulsivity, irritability, anger/hostility, atypical depression, hysteroid dysphoria	B	Second-line treatment after SSRI failure; complete elimination of initial SSRI required before MAOI treatment; adherence to required dietary restrictions problematic; effective for atypical depression only when borderline personality disorder is secondary, not primary, diagnosis
Mood stabilizers	Lithium carbonate	Mood lability, mood swings, anger, suicidality, impulsivity, poor global functioning	C	Can be used as primary or adjunctive treatment (overlaps with treatment of impulsive-behavioral domain); narrow margin of safety in overdose; blood level monitoring required; risk of hypothyroidism; to date, best studied of the mood stabilizers in treatment of personality disorders, but older literature focuses on reduction of impulsive behavior
	Carbamazepine	Suicidality, anxiety, anger, impulsivity	C	Efficacy in patients exhibiting hysteroid dysphoria; can precipitate melancholic depression; risk of bone marrow suppression; blood draws required to monitor WBC count
	Valproate	Global symptom severity, depressed mood, anger, impulsivity, rejection sensitivity, irritability, agitation, aggression, anxiety	C	Paucity of research support for this indication despite widespread use; blood draws required to monitor liver function
Benzodiazepines ^c	Alprazolam, clonazepam	Refractory anxiety, impulsivity, agitation	C	Risk of abuse, tolerance; alprazolam associated with behavioral dyscontrol
Neuroleptics ^c	Haloperidol	Behavioral dyscontrol, anger/hostility, assault, self-injury	A	Rapid onset of effect provides immediate control of behavior

^aRatings used by Jobson and Potter (2): A=supported by two or more randomized, placebo-controlled, double-blind trials; B=supported by at least one randomized, placebo-controlled, double-blind trial; C=supported by open-label studies, case reports, and studies that do not meet standards of randomized, placebo-controlled, double-blind trials. See text for specific supporting studies.

^bA mixed norepinephrine/serotonin reuptake blocker.

^cAgents primarily used as adjunctive treatment.

TABLE 3. Psychopharmacological Treatment Recommendations for Impulsive-Behavioral Dyscontrol Symptoms in Patients With Borderline Personality Disorder

Drug Class	Specific Medications Studied	Symptoms for Which Medication Is Recommended	Strength of Evidence ^a	Issues
SSRIs and related antidepressants	Fluoxetine, sertraline	Impulsive aggression, anger, irritability, self-injurious behavior, poor global functioning	A	Effects on anger and impulsive aggression may appear earlier and independently of effects on depressed mood and anxiety; no published literature on second “salvage” trials if first trial fails to reduce impulsive behavior
MAOIs	Phenelzine, tranylcypromine	Anger, irritability; impulsivity in patients with hysteroid dysphoria	A	Second-line treatment after SSRI failure; complete elimination of initial SSRI required before MAOI treatment; adherence to required dietary restrictions problematic
Mood stabilizers	Lithium carbonate	Impulsive aggression in patients with related personality disorders, impulsive behavior in patients with borderline personality disorder	A	Can be used as primary or adjunctive treatment (overlaps with treatment of affective dysregulation domain); older literature does not address borderline personality disorder; toxicity a concern in overdose; blood monitoring necessary; risk of hypothyroidism with long-term use
	Carbamazepine	Impulsivity in patients with hysteroid dysphoria	C	Risk of precipitating melancholic depression reported; blood monitoring required
	Valproate	Impulsive aggression, agitation; for adolescents with disruptive behavior disorders: tension, anxiety, chronic temper outbursts, poor global functioning	C	Paucity of research support for this indication despite widespread use; one randomized, placebo-controlled, double-blind trial is under way
Atypical neuroleptics	Clozapine	Severe self-mutilation, psychoticism	C	Risk of agranulocytosis renders clozapine treatment a last resort for this indication; blood monitoring required
Typical neuroleptics (low-dose) ^b	Haloperidol	Acute anger, hostility, assaultiveness, self-injury	A	Nonspecific effects on impulsivity as adjunctive agent; more specific effects on anger; rapid onset of effect provides immediate control of escalating impulsive symptoms

^aRatings used by Jobson and Potter (2): A=supported by two or more randomized, placebo-controlled, double-blind trials; B=supported by at least one randomized, placebo-controlled, double-blind trial; C=supported by open-label studies, case reports, and studies that do not meet standards of randomized, placebo-controlled, double-blind trials. See text for specific supporting studies.

^bAgents primarily used as adjunctive treatment.

TABLE 4. Psychopharmacological Treatment Recommendations for Cognitive-Perceptual Symptoms in Patients With Borderline Personality Disorder

Drug Class	Specific Medications Studied	Symptoms for Which Medication Is Recommended	Strength of Evidence ^a	Issues
Typical neuroleptics (low-dose)	Haloperidol, perphenazine, thiothixene, thioridazine, flupentixol, loxapine, chlorpromazine, trifluoperazine	Ideas of reference, illusions, and paranoid ideation (and associated anger/hostility); global symptom severity, depressed mood, anxiety, impulsivity, recurrent suicidal behavior	A	Effects demonstrated in short-term studies (e.g., 5–16 weeks); poor tolerance over longer trials (e.g., 22 weeks) with increased akinesia, depression; reduction of recurrent parasuicidal behaviors reported in one long-term (6-month) study; risk of tardive dyskinesia with maintenance treatment
Atypical neuroleptics	Clozapine, olanzapine, risperidone	In theory, same as for typical neuroleptics as well as self-mutilation and severe, neuroleptic-resistant psychoticism	C	No published randomized, placebo-controlled, double-blind trials in support of this indication despite widespread use; risk of agranulocytosis renders clozapine treatment a last resort for this indication
SSRIs ^b		Irritability, anger/hostility, depressed mood, impulsive aggression	A	Especially effective if affective symptoms are present; overlaps with treatment of affective dysregulation and impulsive-behavioral dyscontrol domains
MAOIs ^b		Same as for SSRIs	A	Adherence to required dietary restrictions problematic

^aRatings used by Jobson and Potter (2): A=supported by two or more randomized, placebo-controlled, double-blind trials; B=supported by at least one randomized, placebo-controlled, double-blind trial; C=supported by open-label studies, case reports, and studies that do not meet standards of randomized, placebo-controlled, double-blind trials. See text for specific supporting studies.

^bAgents primarily used as adjunctive treatment.

BORDERLINE

BEHAVIORAL DEFINITION

- 1. Makes desperate attempts to avoid abandonment.
- 2. Has unstable and intense relationships, usually involving alternately idealizing and denigrating another person.
- 3. Sense of self or self-image is chronically unstable.
- 4. Acts on impulse in ways that can be self-damaging (e.g., over-spending, sex, drugs).
- 5. Makes frequent suicidal gestures or threats or mutilates him-self/herself.
- 6. Has highly unstable moods (e.g., gets depressed, irritable, or anx-ious for brief periods).
- 7. Chronically experiences feelings of emptiness.
- 8. Is easily provoked to anger or rage.
- 9. Under stress, can become paranoid or experience dissociative symptoms.

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LONG-TERM GOALS

- 1. Terminate suicidal and/or self-mutilating behavior.
- 2. Stabilize interpersonal relationships.
- 3. Increase respect for self.

- 4. Increase behavioral skills such as problem-solving and communi-cation skills.
- 5. Increase emotional modulation and decrease emotional reactivity.
- 6. Increase realistic judgment while decreasing crisis-generating be-havior.

SHORT-TERM OBJECTIVES

1. Express satisfaction with therapeutic relationship, either verbally or nonverbally, as indicated by the client conveying difficulties and concerns. (1)
2. Cooperate with psychological assessment. (2, 3)
3. Establish specific treatment goals. (4, 5)
4. Express trust in the relationship with the therapist either verbally or nonverbally. (6, 7, 8)
5. Verbalize an understanding of therapist's policy regarding suicidal behavior. (9, 10)
6. Respond appropriately to having limits set by therapist and/or significant others. (11, 12, 13)
7. Identify the reasons for suicidal ideation and/or self-mutilating behavior and the

THERAPEUTIC INTERVENTIONS

1. Express empathy for the client's difficulties (e.g., feeling out of control, fragile, or having relationship problems) through unconditional positive regard, warm acceptance, and reflective listening.
2. Administer or refer the client for personality testing to assess personality dynamics and emotional/behavioral/cognitive problems.
3. Review and process the results of psychological testing with the client.
4. Assist the client in developing a list of specific dissatisfactions he/she is presently experiencing, such as difficulties with relationships, feelings of emptiness, drug problems, or suicidal ideation.

- factors in the present environment that reward self-harmful ideas and actions. (14, 15)
8. Decrease frequency of or eliminate suicidal gestures, threats, and attempts. (16, 17)
 9. Cooperate with referral to a physician to evaluate the need for psychotropic medication to stabilize mood, decrease anxiety and/or depression, or stabilize thought process. (18)
 10. Take psychotropic medication as prescribed and report on the medication's effectiveness and side effects. (19, 20)
 11. Express anger in an appropriate fashion rather than with rage when responding to feeling wronged, abandoned, or betrayed. (21, 22, 23, 24, 25)
 12. Verbalize feeling more stable and in control of emotions. (26, 27, 28)
 13. Express appropriate displeasure or anger toward a person who generates frustration rather than becoming enraged. (24, 29, 30, 31)
 14. Report reducing or eliminating the use of alcohol and/or drugs. (32, 33, 34, 35)
 15. Verbalize increased capacity to cope with stress. (28, 36)
 16. Learn to self-soothe in healthy and appropriate ways rather than using
5. Explain Dialectical Behavior Therapy protocol (required individual therapy, group skills training meeting, long-term commitment to therapy, and prohibition against suicide attempts and self-mutilation). See *Cognitive Behavior Therapy of Borderline Personality Disorder* (Linehan).
 6. Explicitly acknowledge the client's difficulty with trust and reinforce any expressions of trust in the therapist.
 7. Express self in a clear, straightforward fashion.
 8. Clarify to the client that he/she need not talk about sensitive issues until ready to do so.
 9. Set a policy that telephone contacts with the client for emergencies will be brief and will be limited to dealing with the crisis situation.
 10. Using Dialectical Behavior Therapy, contract with the client during intake that suicidal behavior will lead to automatic dismissal from the program.
 11. Instruct the client regarding the requirements of therapy (regular attendance at sessions, payment schedules, arriving at sessions sober, etc.), and discuss the consequences of failing to comply.
 12. With a colleague, supervisor, or team members, pro-

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- drugs, performing self-mutilation, or engaging in impulsive, potentially dangerous actions. (26, 27, 28, 36)
17. Identify the impact of childhood sexual abuse on present relationships. (37, 38)
 18. Engage in sexual activity that is pleasurable and not dangerous. (35, 38, 39)
 19. Reduce the frequency of distorted, negative thoughts that lower self-esteem; increase frequency of positive thoughts. (27, 40, 41, 42, 43)
 20. Report little or no distress when in between romantic or other close relationships. (26, 27, 44)
 21. Express a firmer sense of self rather than feeling aimless and confused about own values and goals in life. (28, 45)
 22. Report a reduction in feelings of emptiness and depersonalization. (45, 46, 47)
 23. Report being able to cope with feelings of emptiness without resorting to self-mutilation or substance abuse. (26, 27, 28, 48)
 24. Report feeling calm in a situation that previously would have evoked feelings of terror or being overwhelmed. (26, 27, 28, 46, 49)
 25. Calmly accept the loss of a relationship rather than making frantic efforts to
- cess feelings toward the client (e.g., anger, exasperation, or feeling manipulated) that are related to the client's therapy-interfering behaviors (e.g., not showing up at sessions, expecting a friendship or intimate relationship with the therapist) in order to distill perspective and enhance ability to maintain therapeutic alliance.
13. Assign the client (and/or significant others, if appropriate) to read *Boundaries: Where You End and I Begin* (Katherine); process key ideas.
 14. Express compassion for the client's pain that leads to suicidal ideation and/or self-mutilating behavior. Use active listening to understand the depth of pain and suffering experienced by the client from his/her point of view.
 15. Once the therapist fully understands the pain that leads the client to want to die, examine the suicide attempt/gesture as a form of communication (e.g., a message to a significant other, a message to the world). Explore secondary gains received from such behavior (e.g., attention from significant others or medical staff, being taken seriously).
 16. When the therapist fully understands the pain that

- avoid abandonment.
(44, 50, 51)
26. Describe a person or relationship in shades of gray rather than as all good or all bad. (52)
27. Continue to think and act as an adult under stress rather than reverting to childlike behavior. (53)
28. Report having a friendship or intimate relationship that is comfortable and balanced. (54)
- ____.
- ____.
- ____.

- leads the client to want to die, process reasons that the client wants to live. Help the client draw strength and specific treatment goals from this list.
17. Assess with the client the negative consequences of suicidal behavior/gestures on his/her long-term goals.
18. Refer the client to a physician for psychotropic medication evaluation; help the client to process costs and benefits of a medication evaluation.
19. Monitor the client's use of psychotropic medication for compliance with prescription, effectiveness, and side effects. Regularly assess for signs of dependence on or addiction to prescription medication.
20. On a regular basis, confer with prescribing physician about the effectiveness of the psychotropic medication.
21. Explore the history of consequences the client has had with excessive anger; process whether the consequences are consistent with his/her goals at this time.
22. Assign the client readings on assertiveness training (e.g., *Your Perfect Right* by Alberti and Emmons or *When I Say No I Feel Guilty* by Smith); discuss the key points. Emphasize how assertiveness is a tool to increase compliance with

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- requests and get needs met over long periods of time.
23. Use role play, modeling, and behavioral rehearsal with the client to simulate situations that demand assertiveness; provide feedback regarding the appropriateness of his/her responses.
24. Instruct the client to imagine the person who angered him/her is in an empty chair in the room and to express his/her feelings toward that person in a respectful, controlled fashion.
25. When the client becomes angry with the therapist, process the feelings, noting similarities between the therapeutic relationship and other important relationships in the client's life. Work collaboratively toward an appropriate resolution of the angry feelings.
26. Conduct or refer the client to a Core Mindfulness skills training group in order to teach the client how to balance and regulate emotions. (See *Skills Training Manual for Treating Borderline Personality Disorder* by Linehan.)
27. Conduct or refer the client to an Emotional Regulation skills training group in order to teach the client how to balance and regulate emotions. (See *Skills Training Manual for Treating*

- Borderline Personality Disorder* by Linehan.)
28. Train the client to use meditation (e.g., thought-watching exercise) by assigning *Full Catastrophe Living* (Kabat-Zinn) or *How to Meditate* (LeShan), processing key concepts with therapist; demonstrate technique during session and assign practice as homework.
 29. Assign the client to read *Of Course You're Angry* (Rosellini and Worden) or *Managing Anger* (Messer, Coronado-Bogdaniak, and Dillon); process key ideas.
 30. Institute stress inoculation training for anger by preparing the client to recognize early cues and mental precursors of anger, using behavioral rehearsal to establish appropriate responses and establishing self-rewards for maintaining control. (See *Stress Reduction and Prevention* by Meichenbaum and Jaremko.)
 31. Discuss forgiveness of perpetrators of pain as a process of letting go of anger.
 32. Assess the client's substance abuse pattern; if necessary, refer him/her to a chemical dependence treatment program (e.g., Rational Recovery).
 33. Refer the client to Alcoholics Anonymous or Nar-

- cotics Anonymous and have him/her report the impact of those meetings to the therapist.
34. Assist the client in developing a list of life changes needed in order to maintain long-term sobriety; process a plan of implementation of such changes.
 35. Process with the client the reasons for drug/alcohol use (e.g., to numb painful thoughts, to facilitate sex, to cope with memories of sexual abuse, or to “feel alive”). Discuss alternative strategies to meet those needs. (See *The Chemical Dependence Treatment Planner* by Perkinson and Jongsma.)
 36. Conduct or refer the client to a Distress Tolerance skills training group. (See *Skills Training Manual for Treating Borderline Personality Disorder* by Linehan.)
 37. Explore the client’s history of being sexually abused; discuss the impact that his/her experience has had on increasing promiscuity and decreasing sexual pleasure.
 38. Discuss the impact of being sexually abused on the ability to trust others.
 39. Assess the client’s knowledge of sexually transmitted disease and condom use; educate the client if necessary.
 40. Use thought-stopping technique (having the client

- shout “Stop” silently when-ever negative thoughts come to mind until the thought dissipates and can be replaced with pleasant, positive thoughts).
41. Assign the client to read *The Six Pillars of Self-Esteem* (Brandon), *Self-Esteem* (McKay and Fanning), or *Ten Days to Self-Esteem* (Burns); process central ideas with therapist.
 42. Assign the client to keep a record of dysfunctional thoughts such as “I’m too inadequate to handle life on my own” and “I’m stupid.” Using Socratic dialogue, challenge the client to examine the evidence for and against such statements.
 43. Empathize with the client’s feelings of low self-esteem. The therapist must be aware of his/her own feelings as they are impacted by the client and, assuming the therapeutic relationship is sufficiently established, provide feedback to the client about those feelings, thus facilitating perspective on the part of the client.
 44. Challenge and dispute the client’s irrational beliefs regarding being alone (e.g., “It is awful to be alone,” “If I disagree with someone I will be abandoned, which would be horrible”). Replace extreme reactions with less extreme ones (e.g., it would

- be inconvenient to be alone or to break up).
45. Explore aspects of the client's life that provide a sense of meaning, purpose, or mission. Inquire about spiritual or religious participation that provides fortitude, comfort, or meaning to life; encourage increased participation.
 46. Teach the client to increase his/her body awareness through an assigned exercise such as having the person lie in a quiet room and pay attention to psychokinesthetic stimuli. (See "Body Scan" exercise in *Full Catastrophe Living* by Kabat-Zinn.)
 47. Ask the client to list any activity or relationship that would increase satisfaction or meaning to his/her life; process how to include that activity or relationship more consistently in his/her life.
 48. Explore the client's reasons for engaging in self-mutilation, substance abuse, or suicidal gestures; develop adaptive coping behaviors to overcome the tension associated with feelings of emptiness/detachment (implement relaxation techniques, call a friend or family member, engage in a self-soothing exercise, utilize spiritual meditation, practice vigorous physical exercise, etc.).
 49. To increase the client's feelings of confidence in social

situations, provide relationship skills training, including a focus on *sending skills* (delivering a message to others), *receiving skills* (getting a message from others), and *processing skills* (choosing which skill to use in a particular situation). (See *Social Skills Training for Psychiatric Patients* by Liberman, DeRisi, and Mueser.)

50. Challenge the client's catastrophizing (e.g., the belief that the end of the relationship is a disaster that will lead to endless loneliness and isolation), replacing the irrational belief with more balanced ones (e.g., endings are painful, but the pain subsides and new beginnings emerge).
51. Process the client's thoughts and feelings about ending therapy, facilitating his/her ending this relationship differently from others.
52. Challenge all-or-none thinking by asking the client to recall or imagine instances in which someone was average rather than extreme on a particular dimension (e.g., a person who was neither awesomely talented nor completely inept, a person who elicited friendly feelings rather than total love or total hatred).
53. When the client experiences regression during a session, analyze the impact of regressive actions on the ther-

- apeutic relationship; process this with the client.
54. Refer the client to an Interpersonal Effectiveness skills training group, in which the client can learn to decrease worry, increase self-respect, learn to balance “wants” and “shoulds” in relationships, and set appropriate limits in relationships. (See *Skills Training Manual for Treating Borderline Personality Disorder* by Linehan.)
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DIAGNOSTIC SUGGESTIONS

Axis I:	309.81	Posttraumatic Stress Disorder
	296.89	Bipolar II Disorder
	300.14	Dissociative Identity Disorder
	304.80	Polysubstance Dependence
	296.xx	Major Depressive Disorder
Axis II:	301.83	Borderline Personality Disorder
	301.7	Antisocial Personality Disorder
	301.50	Histrionic Personality Disorder
	301.6	Dependent Personality Disorder
	301.9	Personality Disorder NOS (Passive-Aggressive/Negativistic)

BORDERLINE—PETULANT

BEHAVIORAL DEFINITION

- 1. Is generally negativistic, sullen, pessimistic, and easily disillusioned.
 - 2. Tends to be impatient and restless.
 - 3. Is stubborn and defiant and has difficulty with authority figures.
 - 4. Has deep, ambivalent feelings about connecting to others, fears losing independence, and dreads isolation and abandonment.
 - 5. Is hypersensitive to criticism and easily feels slighted.
 - 6. Is prone to brief, transient psychotic episodes, especially with mood-dominated features (e.g., delusions of worthlessness).
 - 7. Is prone to suicidal gestures and behaviors.
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LONG-TERM GOALS

- 1. Decrease suicidal and/or self-mutilating behavior.
- 2. Stabilize interpersonal relationships.
- 3. Increase self-esteem and emotional stability.
- 4. Increase behavioral skills, such as deferring gratification and tolerating criticism, problem solving, and communication skills.
- 5. Resolve ambivalence regarding independence from versus connection to others.
- 6. Reduce sensitivity to criticism.

- 7. Reduce frequency and severity of brief psychotic episodes.
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SHORT-TERM OBJECTIVES

- 1. Express satisfaction with therapeutic relationship, either verbally or nonverbally, as indicated by the client conveying difficulties and concerns. (1)
- 2. Identify specific emotional, relational, or behavioral problems. (2)
- 3. Express trust in the relationship with the therapist either verbally or nonverbally. (3, 4, 5)
- 4. Verbalize an understanding of therapist's policy regarding emergency contact. (6)
- 5. Make a contract for no self-harm between sessions. (7)
- 6. Respond appropriately to having limits set by therapist. (8, 9, 10)
- 7. Identify the reasons for suicidal ideation and/or self-mutilating behavior and the factors in the present environment that reward self-harmful ideas and actions. (11)

THERAPEUTIC INTERVENTIONS

- 1. Express empathy for the client's difficulties (e.g., feeling unappreciated, resentful, or having relationship problems) through unconditional positive regard, warm acceptance, and reflective listening.
- 2. Assist the client in developing a list of specific dissatisfactions he/she is presently experiencing, such as difficulties with relationships, feelings of emptiness, drug problems, or suicidal ideation; emphasize how treatment is a way of getting his/her needs met.
- 3. Explicitly acknowledge the client's difficulty with trust and reinforce any expressions of trust in the therapist.
- 4. Express self in a clear, straightforward fashion, eliminating any jargon that might be misinterpreted by the client.

BORDERLINE—PETULANT

BEHAVIORAL DEFINITION

- 1. Is generally negativistic, sullen, pessimistic, and easily disillusioned.
- 2. Tends to be impatient and restless.
- 3. Is stubborn and defiant and has difficulty with authority figures.
- 4. Has deep, ambivalent feelings about connecting to others, fears losing independence, and dreads isolation and abandonment.
- 5. Is hypersensitive to criticism and easily feels slighted.
- 6. Is prone to brief, transient psychotic episodes, especially with mood-dominated features (e.g., delusions of worthlessness).
- 7. Is prone to suicidal gestures and behaviors.

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LONG-TERM GOALS

- 1. Decrease suicidal and/or self-mutilating behavior.
- 2. Stabilize interpersonal relationships.
- 3. Increase self-esteem and emotional stability.
- 4. Increase behavioral skills, such as deferring gratification and tolerating criticism, problem solving, and communication skills.
- 5. Resolve ambivalence regarding independence from versus connection to others.
- 6. Reduce sensitivity to criticism.

- 8. Decrease frequency of or eliminate suicidal gestures, threats, and attempts. (12, 13)
 - 9. Cooperate with referral to a physician to evaluate the need for psychotropic medication to stabilize mood, decrease anxiety and/or depression, or stabilize thought process. (14)
 - 10. Take psychotropic medication as prescribed and report on the medication's effectiveness and side effects. (15, 16)
 - 11. Express anger in an appropriate fashion rather than with rage or resentment when responding to feeling wronged, abandoned, or betrayed. (17, 18, 19, 20)
 - 12. Verbalize feeling calm and relaxed in situations that would have previously evoked feelings of anger, resentment, or frustration. (21, 22, 23)
 - 13. Verbalize feeling more stable and in control of emotions. (22, 24)
 - 14. Describe an experience as neutral, tolerable, or humorous that was previously considered provocative or anxiety provoking. (24, 25)
 - 15. Verbalize increased capacity to cope with stress. (21, 22, 23, 24, 26)
 - 16. Rather than becoming enraged or resentful, express appropriate displeasure or
- 5. Clarify to the client that he/she need not talk about sensitive issues until ready to do so.
 - 6. Set a policy that telephone contacts with the client for emergencies will be brief and will be limited to dealing with the crisis situation.
 - 7. Contract with the client not to engage in self-harm behavior between sessions; if necessary, have the client sign a written no-self-harm contract.
 - 8. Instruct the client regarding the requirements of therapy (regular attendance at sessions, payment schedules, arriving at sessions sober, etc.); discuss the consequences of failing to comply.
 - 9. Address fears of abandonment; assure the client that the therapeutic relationship, within the limits discussed, is resilient and secure.
 - 10. With a colleague, supervisor, or team members, process feelings toward the client (e.g., anger, exasperation, feelings of hopelessness) that are related to the client's therapy-interfering behaviors (e.g., not showing up at sessions, expecting a *friendship or intimate relationship* with the therapist) in order to distill perspective and enhance ability to maintain therapeutic alliance.

BORDERLINE—SELF-DESTRUCTIVE

BEHAVIORAL DEFINITIONS

- 1. Has punitive feelings (anger and guilt) toward self.
- 2. Feels hopeless, helpless, and powerless.
- 3. Has history of conforming, deferential, and ingratiating behavioral pattern.
- 4. Makes frequent suicidal gestures or threats or mutilates him- self/herself.
- 5. Is high-strung, moody, and easily angered toward others.
- 6. Is hypervigilant and fearful.
- 7. Is hypersensitive to any distorted perception of being abandoned.

SHORT-TERM OBJECTIVES

- 1. Express satisfaction with therapeutic relationship, either verbally or nonver- bally, as indicated by the client conveying difficulties and concerns. (1)
- 2. Identify sources of feelings of dissatisfaction with self and others. (2)
- 3. Express trust in the rela- tionship with the therapist either verbally or nonver- bally. (3, 4, 5)
- 4. Verbalize an understanding of therapist's policy regard- ing self-destructive behav- ior. (6, 7)
- 5. Agree to the structure of the psychotherapy format. (8)
- 6. Identify the reasons for sui- cidal ideation and/or self- mutilating behavior and the factors in the present envi- ronment that reward self- harmful ideas and actions. (9, 10)
- 7. Decrease frequency of or eliminate suicidal gestures, threats, and attempts and

THERAPEUTIC INTERVENTIONS

- 1. Express empathy for the client's difficulties (e.g., feeling self-destructive, des- perate, or having relation- ship problems) through unconditional positive re- gard, warm acceptance, and reflective listening.
- 2. Assist the client in develop- ing a list of specific dissatis- factions he/she is presently experiencing, such as feel- ings of helplessness, hope- lessness, or suicidal ideation.
- 3. Explicitly acknowledge the client's difficulty with trust; reinforce any expressions of trust in the therapist.
- 4. Express self in a clear, straightforward fashion, free from jargon that could be misinterpreted by the client.
- 5. Clarify to the client that he/she need not talk about sensitive issues until ready to do so.
- 6. Set a policy that telephone contacts with the client for

BORDERLINE—SELF-DESTRUCTIVE

BEHAVIORAL DEFINITIONS

1. Has punitive feelings (anger and guilt) toward self.
2. Feels hopeless, helpless, and powerless.
3. Has history of conforming, deferential, and ingratiating behavioral pattern.
4. Makes frequent suicidal gestures or threats or mutilates himself/herself.
5. Is high-strung, moody, and easily angered toward others.
6. Is hypervigilant and fearful.
7. Is hypersensitive to any distorted perception of being abandoned.

- increase hopeful statements about life and the future. (11, 12)
8. Cooperate with a referral to a physician to evaluate the need for psychotropic medication to stabilize mood, decrease anxiety and/or depression, or stabilize thought process. (13)
9. Take psychotropic medication as prescribed and report on the medication's effectiveness and side effects. (14, 15)
10. Report situations in which increased capacity to cope with stress was demonstrated. (16, 17, 18)
11. Verbalize feeling more stable and in control of emotions. (16, 17, 18)
12. Learn to self-soothe in healthy and appropriate ways rather than engaging in substance abuse, self-mutilation, or suicidal gestures/ideation. (16, 17, 18, 19, 20)
13. Reduce the frequency of distorted, negative thoughts that lower self-esteem. (21, 22, 23)
14. Identify the impact of childhood sexual abuse on present relationships. (24, 25)
15. Verbalize understanding of the connection between prior abuse and present punitive feelings, beliefs, and behaviors. (26)
- emergencies will be brief and will be limited to dealing with the crisis situation.
7. Contract with the client not to engage in self-harm between sessions.
8. Instruct the client regarding the requirements of therapy (regular attendance at sessions, payment schedules, arriving at sessions sober, etc.); discuss the consequences of failing to comply.
9. Express compassion for the client's pain that leads to suicidal ideation and/or self-mutilating behavior. Use active listening to understand the depth of pain and suffering experienced by the client from his/her point of view.
10. Once the therapist fully understands the pain that leads the client to want to die, examine the suicide attempt/gesture as a form of communication (e.g., a message to a significant other, a message to the world). Explore secondary gains received from such behavior (e.g., attention from significant others or medical staff, being taken seriously).
11. When the therapist fully understands the pain that leads the client to want to die, process reasons that the client wants to live. Help the client draw strength and specific treatment goals from this list.

BORDERLINE—SELF-DESTRUCTIVE

BEHAVIORAL DEFINITIONS

1. Has punitive feelings (anger and guilt) toward self.
2. Feels hopeless, helpless, and powerless.
3. Has history of conforming, deferential, and ingratiating behavioral pattern.
4. Makes frequent suicidal gestures or threats or mutilates himself/herself.
5. Is high-strung, moody, and easily angered toward others.
6. Is hypervigilant and fearful.
7. Is hypersensitive to any distorted perception of being abandoned.

16. Verbalize positive beliefs about self, including acceptance of own intrinsic value. (27, 28, 29)
17. Express anger in a healthy fashion rather than becoming enraged at himself/herself. (30, 31)
18. Express self assertively rather than becoming guilty or punitive. (32, 33)
19. Reduce or eliminate patterns of impulsive expression of anger and resentment followed by guilt and contrition. (24, 30, 32, 33, 34)
20. Acknowledge that own needs and desires are independent of what others want; state how they can be reasonably satisfied. (32, 35)
21. Risk displeasing someone in order to meet own needs in an area that is considered important. (32, 33, 35, 36)
22. Set limits on another person without feeling guilty. (32, 33, 37)
23. Acknowledge that behaviors often elicit a great deal of guilt from others. (10, 12, 38)
24. Verbalize an understanding of the destructive impact of excessive guilt on the self and on relationships. (38, 39)
25. Identify resentments held toward others (including the therapist, if applicable) that have been previously
12. Assess with the client the negative consequences of suicidal behavior/gestures on his/her long-term goals.
13. Refer the client to a physician for psychotropic medication evaluation; help the client to process costs and benefits of a medication evaluation.
14. Monitor the client's use of psychotropic medication for compliance with prescription, effectiveness, and side effects. Regularly assess for signs of dependence on or addiction to prescription medication.
15. On a regular basis, confer with prescribing physician about the effectiveness of the psychotropic medication.
16. Train the client to use meditation (e.g., thought-watching exercise) by assigning *Full Catastrophe Living* (Kabat-Zinn) or *How to Meditate* (LeShan), processing key concepts with therapist; demonstrate technique during session and assign practice as homework.
17. Provide the client with relaxation training utilizing progressive muscular relaxation, self-hypnosis, autogenics training, and/or visualization; assign the client to use these techniques at times of stress.
18. Institute stress inoculation training for dealing with

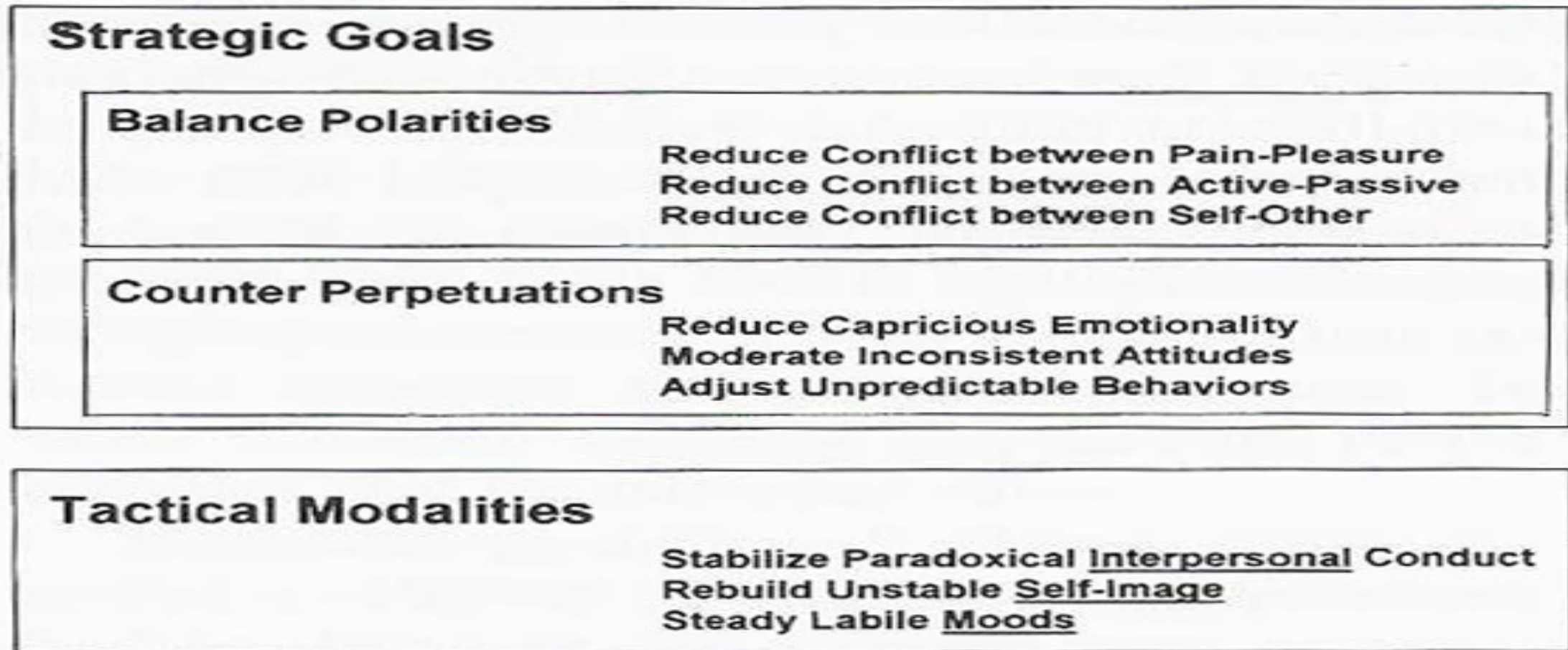


Figure 18.6 Therapeutic strategies and tactics for the prototypal borderline personality.

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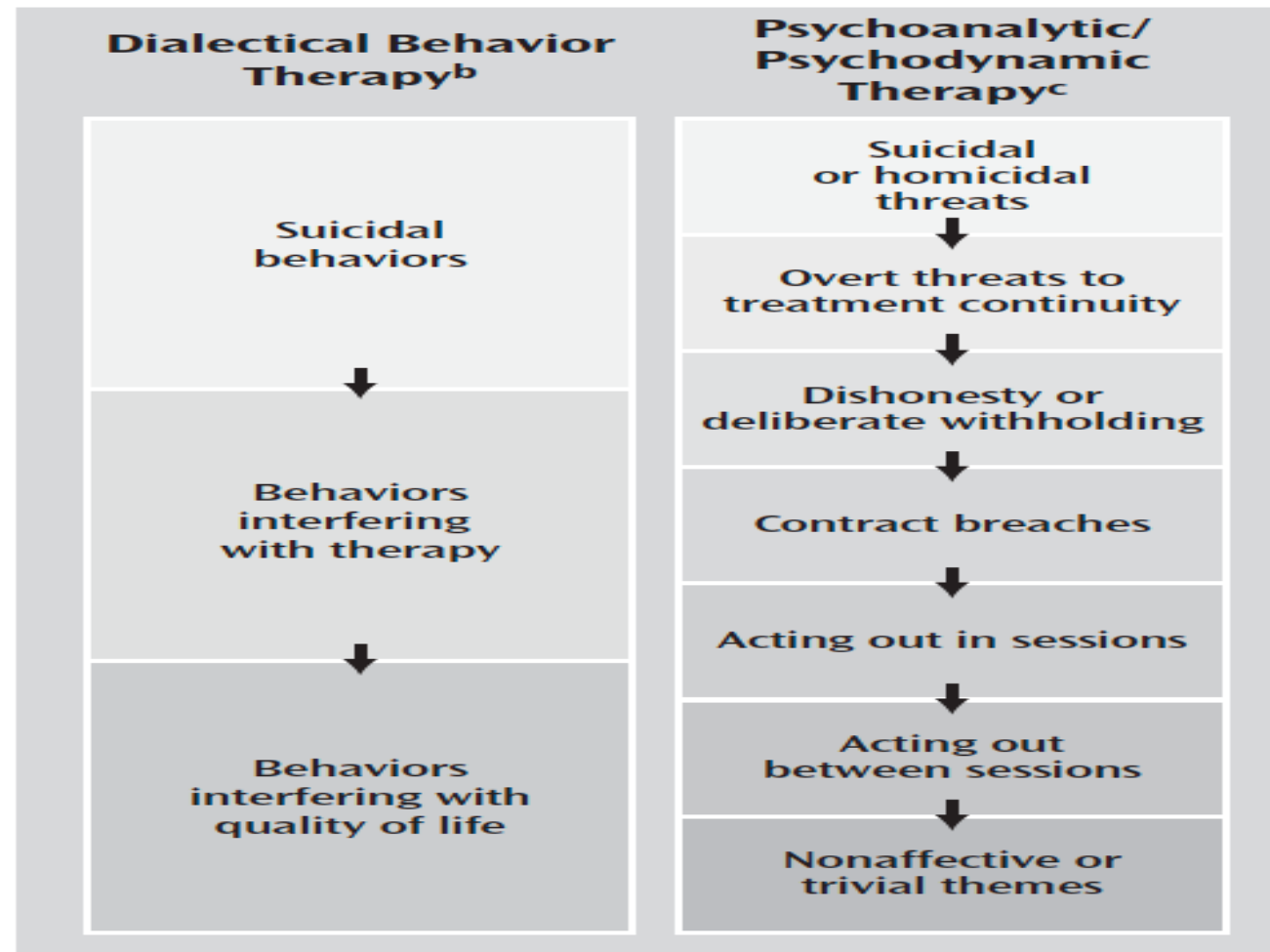


FIGURE 1. Treatment Priorities of Two Psychotherapeutic Approaches for Patients With Borderline Personality Disorder.^a

^aSpecific behaviors that practitioners of each approach may encounter in patients with borderline personality disorder are presented, with those of highest priority sitting atop the “ladder”; treatment priority lessens as one goes down the ladder.

^bAs described by Linehan et al. (5).

^cAs described by Kernberg et al. (4) and Clarkin et al. (13).

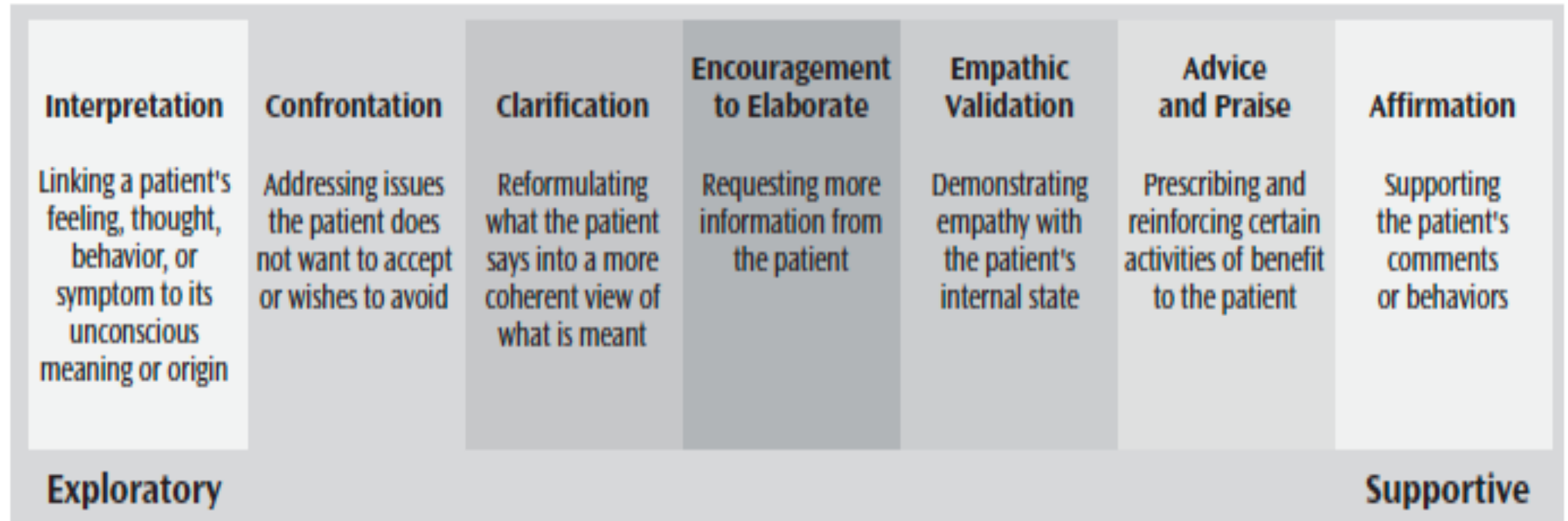


FIGURE 2. The Exploratory-Supportive Intervention Continuum of Psychodynamic Psychotherapy.

Source. Adapted from Gabbard (139).

TABLE 18.1 Clinical Domains of the Borderline Prototype

Behavioral Level

(F) *Expressively Spasmodic*. Displays a desultory energy level with sudden, unexpected, and impulsive outbursts; abrupt, endogenous shifts in drive state and inhibitory controls; not only places activation and emotional equilibrium in constant jeopardy, but engages in recurrent suicidal or self-mutilating behaviors.

(F) *Interpersonally Paradoxical*. Although needing attention and affection, is unpredictably contrary, manipulative, and volatile, frequently eliciting rejection rather than support; frantically reacts to fears of abandonment and isolation, but often in angry, mercurial, and self-damaging ways.

Intrapsychic Level

(F) *Regression Mechanism*. Retreats under stress to developmentally earlier levels of anxiety tolerance, impulse control, and social adaptation; among adolescents, is unable to cope with adult demands and conflicts, as evident in immature, if not increasingly infantile behaviors.

(S) *Split Organization*. Inner structures that exist in a sharply segmented and conflictful configuration in which a marked lack of consistency and congruency is seen among elements; levels of consciousness often shift and result in rapid movements across boundaries that usually separate contrasting percepts, memories, and affects; this leads to periodic schisms in what limited psychic order and cohesion may otherwise be present, often resulting in transient, stress-related psychotic episodes.

Phenomenological Level

(F) *Cognitively Capricious*. Experiences rapidly changing, fluctuating, and antithetical perceptions or thoughts concerning passing events, as well as contrasting emotions and conflicting thoughts toward self and others, notably love, rage, and guilt; vacillating and contradictory reactions are evoked in others by virtue of one's behaviors, creating, in turn, conflicting and confusing social feedback.

(S) *Uncertain Self-Image*. Experiences the confusions of an immature, nebulous, or wavering sense of identity, often with underlying feelings of emptiness; seeks to redeem precipitate actions and changing self-presentations with expressions of contrition and self-punitive behaviors.

(S) *Incompatible Objects*. Internalized representations comprise rudimentary and extemporaneously devised, but repetitively aborted learnings, resulting in conflicting memories, discordant attitudes, contradictory needs, antithetical emotions, erratic impulses, and clashing strategies for conflict reduction.

Biophysical Level

(S) *Labile Mood*. Fails to accord unstable mood level with external reality; has either marked shifts from normality to depression to excitement, or has periods of dejection and apathy, interspersed with episodes of inappropriate and intense anger, as well as brief spells of anxiety or euphoria.

(F) = Functional domain.

(S) = Structural domain.

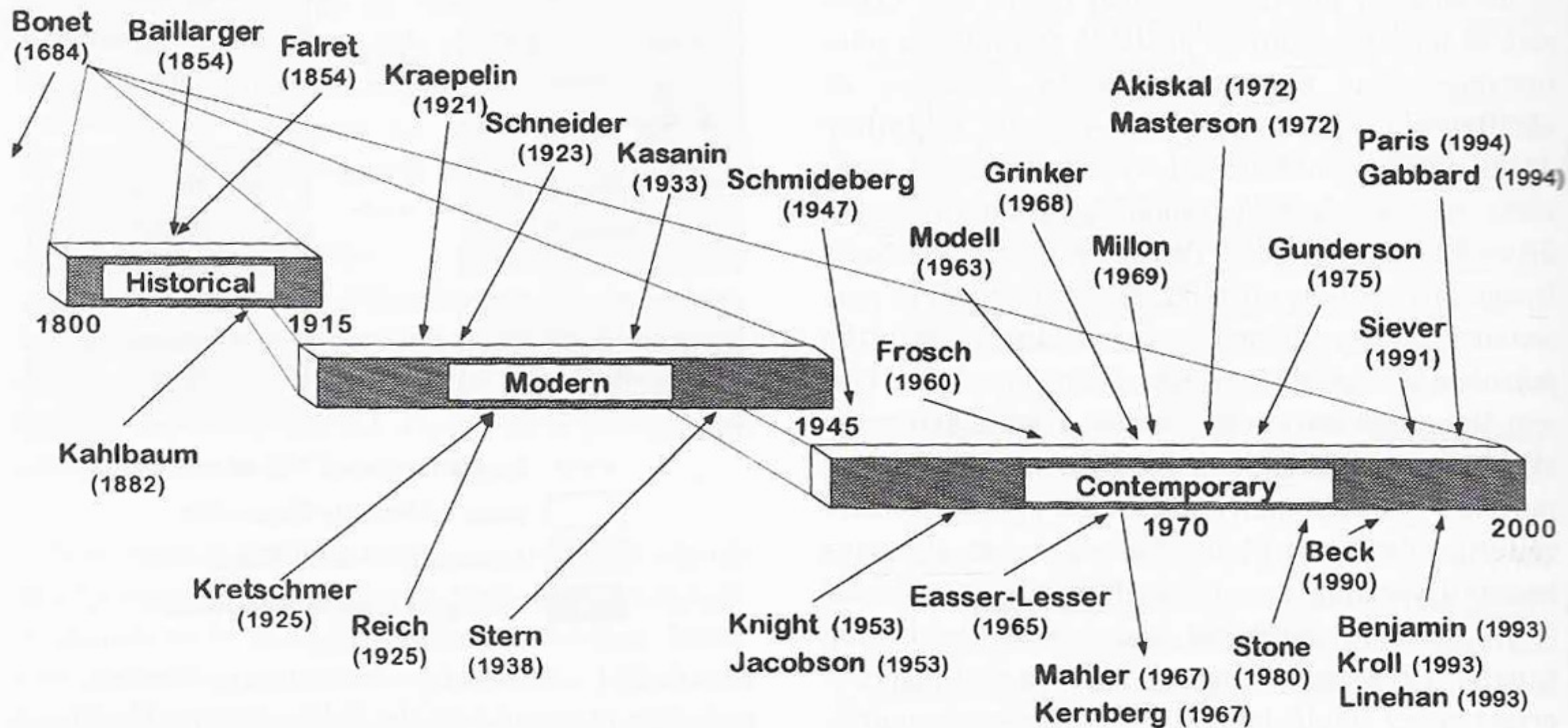


Figure 18.2 Historical review of major contributors to the borderline personality disorder.

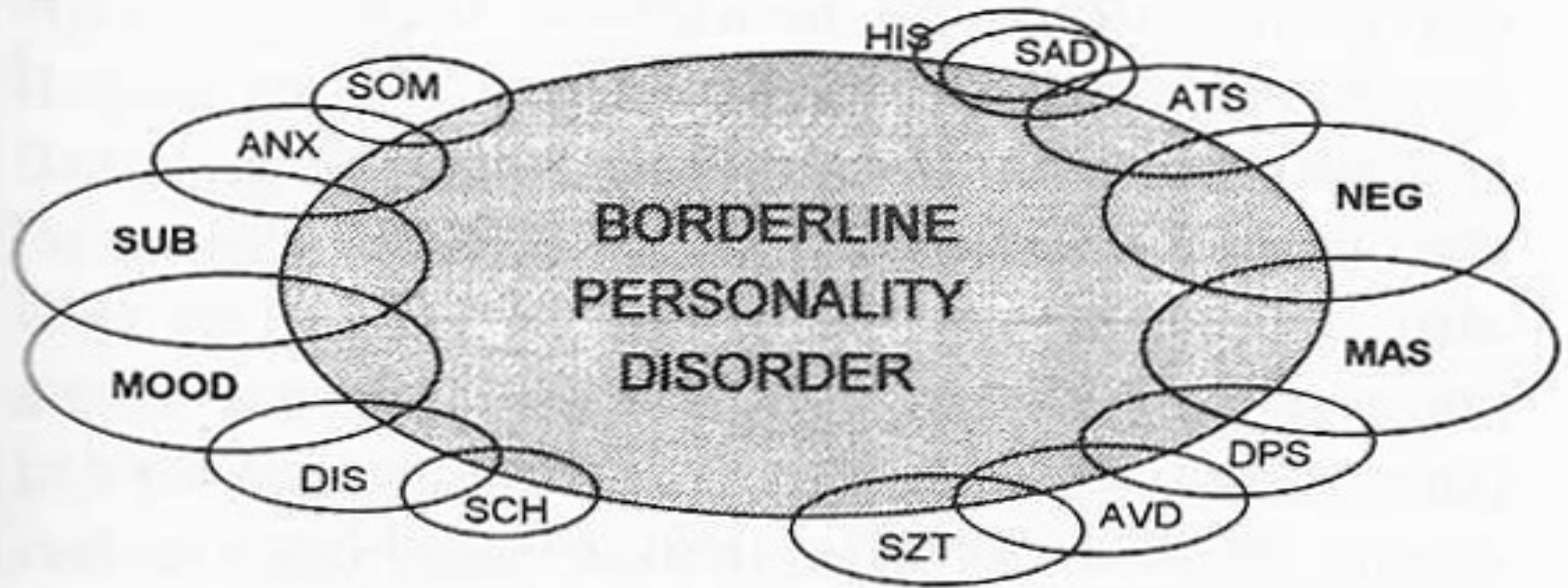


Figure 18.4 Comorbidity between borderline personality disorder and other DSM Axis I and Axis II disorders.

BORDERLINE PROTOTYPE

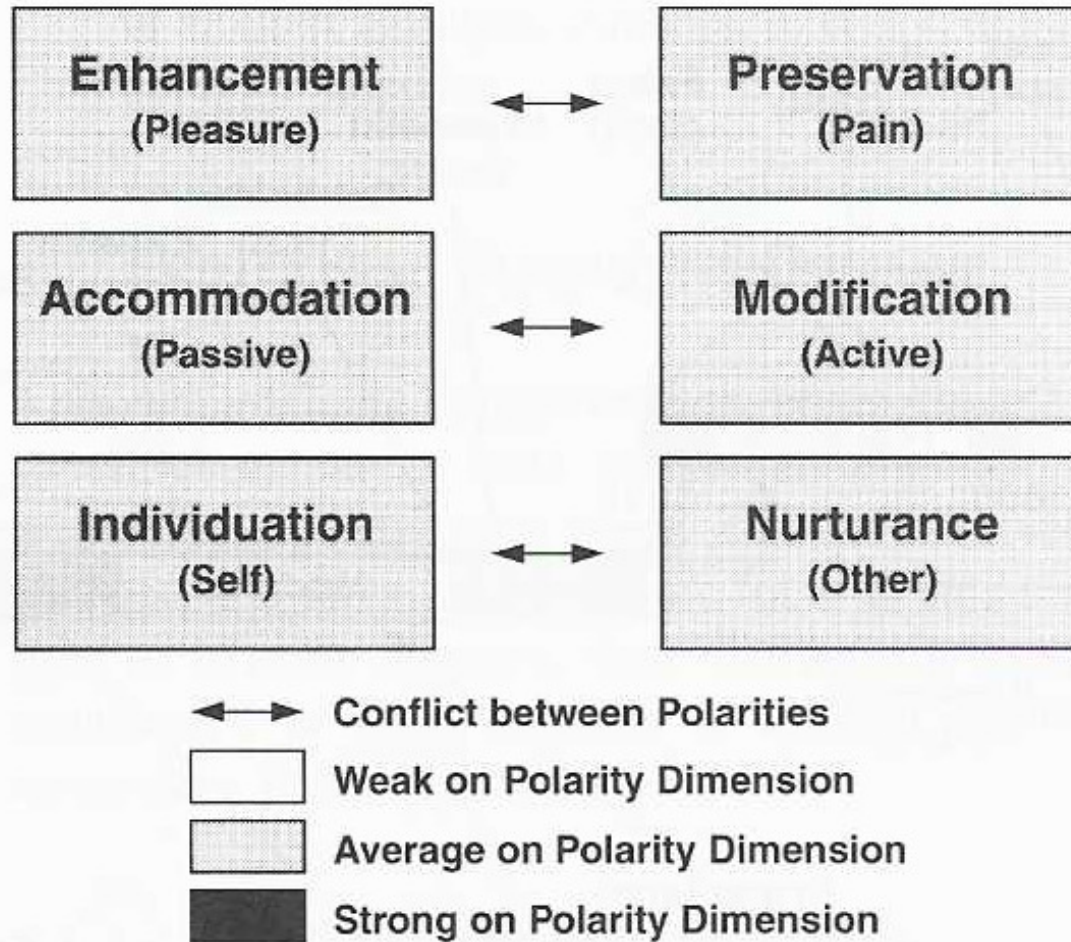


Figure 18.1 Status of the borderline personality prototype in accord with the Millon Polarity Model.

Strategic Goals

Balance Polarities

Reduce Conflict between Pain-Pleasure
 Reduce Conflict between Active-Passive
 Reduce Conflict between Self-Other

Counter Perpetuations

Reduce Capricious Emotionality
 Moderate Inconsistent Attitudes
 Adjust Unpredictable Behaviors

Tactical Modalities

Stabilize Paradoxical Interpersonal Conduct
 Rebuild Unstable Self-Image
 Steady Labile Moods

Figure 18.6 Therapeutic strategies and tactics for the prototypal borderline personality.

Table 4.1
Comparison of Borderline Personality Style and Disorder

<i>Personality Style</i>	<i>Personalty Disorder</i>
Tend to experience passionate, focused attachments in all relationships. Nothing in the relationship is taken lightly	Pattern of unstable and intense relationships noted by alternating between extremes of overidealization and devaluation
Emotionally active and reactive, they show their feelings and put their hearts into everything	Impulsive in at least two areas that are potentially self-damaging, e.g., spending, sex, substance abuse, shoplifting, reckless driving, binge eating, suicidal threats, gestures, or behavior
Tend to be uninhibited, spontaneous, fun-loving, and undaunted by risk	Affective instability marked by shifts from baseline mood to depression, irritability or anxiety usually lasting a few hours and only rarely more than a few days

Tend to be creative, lively, busy, and engaging individuals. They show initiative and can stir others to activity

Imaginative and curious, they are willing to experience and experiment with other cultures and value systems

Regularly tend to be deeply involved in a romantic relationship with one person

Inappropriate, intense anger or lack of control of anger, e.g., frequent displays of temper, constant anger, recurrent physical fights; chronic feelings of emptiness or boredom

Marked and persistent identity disturbance characterized by uncertainty about at least two of the following: self-image, sexual orientation, long-term goals or career choice, type of friends desired, preferred values

Frantic efforts to avoid real or imagined abandonment

TABLE 2.2. Typical Overdeveloped and Underdeveloped Strategies

Personality disorder	Overdeveloped	Underdeveloped
Obsessive-compulsive	Control Responsibility Systematization	Spontaneity Playfulness
Dependent	Help seeking Clinging	Self-sufficiency Mobility
Passive-aggressive	Autonomy Resistance Passivity Sabotage	Intimacy Assertiveness Activity Cooperativeness
Paranoid	Vigilance Mistrust Suspiciousness	Serenity Trust Acceptance
Narcissistic	Self-aggrandizement Competitiveness	Sharing Group identification
Antisocial	Combativeness Exploitativeness Predation	Empathy Reciprocity Social sensitivity
Schizoid	Autonomy Isolation	Intimacy Reciprocity
Avoidant	Social vulnerability Avoidance Inhibition	Self-assertion Gregariousness
Histrionic	Exhibitionism Expressiveness Impressionism	Reflectiveness Control Systematization

Beck et al, 1991

TABLE 5.1. Examples of a Therapist's Disrespectful Behaviors

1. Misses or forgets appointments
2. Cancels appointments without rescheduling
3. Arbitrarily changes his or her policies with the patient (e.g., changes phone policy, fees, appointment times)
4. Does not return messages or phone calls, or delays calling back
5. Loses papers/files/notes
6. Does not read the notes/papers patient gives him or her
7. Is late for appointments
8. Appears or dresses unprofessionally
9. Has poor physical hygiene
10. Has a messy or unclean office space
11. Smokes during appointments
12. Eats/chews gum during appointments
13. Does not close the door during therapy sessions
14. Allows interruptions such as phone calls or messages
15. Is inattentive during sessions or phone calls, or engages in other activities
16. Forgets important information (name, relevant history/information)
17. Repeats self, often forgets what he or she said
18. Appears visibly tired or fatigued
19. Dozes off when with the patient
20. Avoids eye contact
21. Talks about other patients
22. Talks about how he or she would rather be doing something else
23. Watches the clock when with the patient
24. Ends sessions prematurely
25. Refers to patient in a sexist, paternalistic, or maternalistic manner
26. Treats patient as inferior to the therapist

Note. From *Developing a Scale to Measure Individuals' Stress-Proneness to Behaviors of Human Service Professionals* by M. Miller, 1990, unpublished manuscript, University of Washington. Reprinted by permission of the author.

Linehan, 1993

TABLE 9.3

“Early Maladaptive Schemas” Hypothesized by Young to be Characteristic of Borderline Personality Disorder

Early Maladaptive Schema	Possible Expression
Abandonment/loss	“I’ll be alone forever. No one will be there for me.”
Unlovability	“No one would love me or want to be close to me if they really got to know me.”
Dependence	“I can’t cope on my own. I need someone to rely on.”
Subjugation/lack of individuation	“I must subjugate my wants to the desires of others or they’ll abandon me or attack me.”
Mistrust	“People will hurt me, attack me, take advantage of me. I must protect myself.”
Inadequate self-discipline	“It isn’t possible for me to control myself or discipline myself.”
Fear of losing emotional control	“I must control my emotions or something terrible will happen.”
Guilt/punishment	“I’m a bad person. I deserve to be punished.”
Emotional deprivation	“No one is ever there to meet my needs, to be strong for me, to care for me.”

Note. Adapted from *Schema-Focused Cognitive Therapy for Personality Disorders* by J. Young, 1987, unpublished manuscript. Adapted by permission of the author.

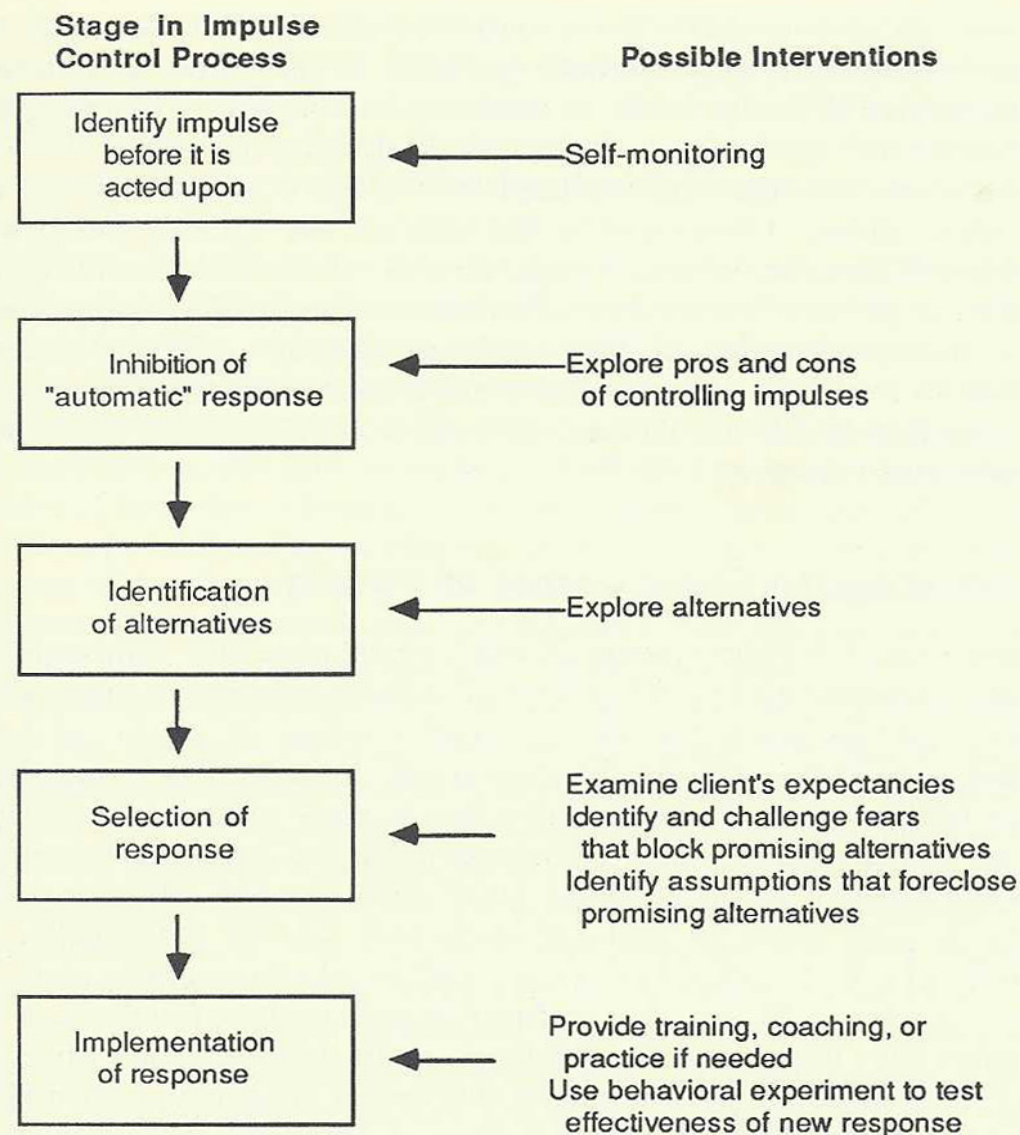


FIGURE 9.1 Possible points for intervention in the impulse control process.

Beck et al, 1991

Examples of Automatic Thoughts

Although each person's automatic thoughts will be unique, here are some generalized examples of what your automatic thoughts might be, based on the personality disorder(s) you're struggling with:

- **Antisocial personality disorder:** "The rules aren't meant for me." "I'm not responsible for anything." "Why should I care?" "Other people aren't as important as I am." "Other people get what they deserve."
- **Avoidant personality disorder:** "Everyone is always judging me." "Those people will criticize me." "I'm no good at making friends." "Other people are better than I am." "There's something wrong with me."
- **Borderline personality disorder:** "I don't want to be left alone." "No one understands me." "I always get hurt by others." "I'm worthless." "I'm empty inside."
- **Dependent personality disorder:** "I can't take care of myself." "I always need help." "I'm not smart enough." "If I do anything wrong, I'll be punished." "I shouldn't disagree with others."
- **Histrionic personality disorder:** "Other people should like me." "I need to be the center of attention." "I must please others." "If other people don't like me, I'll be left alone." "I need to be seductive in order to be liked."
- **Narcissistic personality disorder:** "I'm better than other people at most things." "Other people should compliment me more often." "I'm entitled to special privileges." "Very few people can truly understand me." "Other people should help me get what I want."
- **Obsessive-compulsive personality disorder:** "I need to keep everything in order." "I should never make a mistake." "If I mess up, I'll be punished." "I should always follow the rules." "I must always strive for perfection."
- **Paranoid personality disorder:** "I can't trust anyone." "People are trying to harm me." "I often feel threatened by others." "People will betray me if given the chance." "Others don't deserve my forgiveness."
- **Schizoid personality disorder:** "I'd rather be alone." "I don't know how to act around other people." "I'm very awkward in social situations." "Why bother trying? I'll just embarrass myself." "I don't need others' approval."
- **Schizotypal personality disorder:** "I don't fit in with the rest of society." "I don't know how to behave in social situations." "No one understands my special abilities." "I don't want to be alone." "People often try to take advantage of me."
- **Personality disorder not otherwise specified:** "Other people get special privileges that I don't." "Other people always have it easier than me." "Why should I care? No one helps me." "I'm never going to feel happy." "There's always something wrong with me."

Wood, 2010

**Table 7.3 Therapeutic Strategies and Tactics for the Prototypal Capricious/
Borderline Personality**

Strategic Goals

Balance Polarities

- Reduce conflict between pain–pleasure
- Reduce conflict between active–passive
- Reduce conflict between self–other

Counter Perpetuations

- Reduce capricious emotionality
- Moderate inconsistent attitudes
- Adjust unpredictable behaviors

Tactical Modalities

- Stabilize paradoxical *interpersonal* conduct
 - Rebuild unstable *self-image*
 - Steady labile *moods*
-

	MBT	TFP	CAT	DBT	TC
Framework Frequency Length Setting	2–5 x week 18-months OPD/Partial Hospital	2 x week 1 year OPD	1 x week 6 months OPD	2 x week 1 year In-patient/OPD	5 x week 1–2 years In-patient
Key Constructs	Self-structure Psychic equivalence Pretend Mode Teleological Stance Mentalization	Object relationships Identity diffusion Aggression	Reciprocal roles Self states	Affect dysregulation Invalidating environment Dialectical failure	Communality Permissiveness Democracy Social analysis
Modalities	Individual Group analytic Expressive	Individual	Individual	Individual Social skills group Homework	Groups
Core Techniques	Interpretation Transference Mentalizing Affect and meaning Integrated psychiatric care	Interpretation Transference	Reformulation Interpretation	Problem solving Validation Skills training Affect control Mindfulness	Sharing Social understanding

Fig. 4.1 Comparison of treatments.