Borderline Personality Disorder: From the Inside Out

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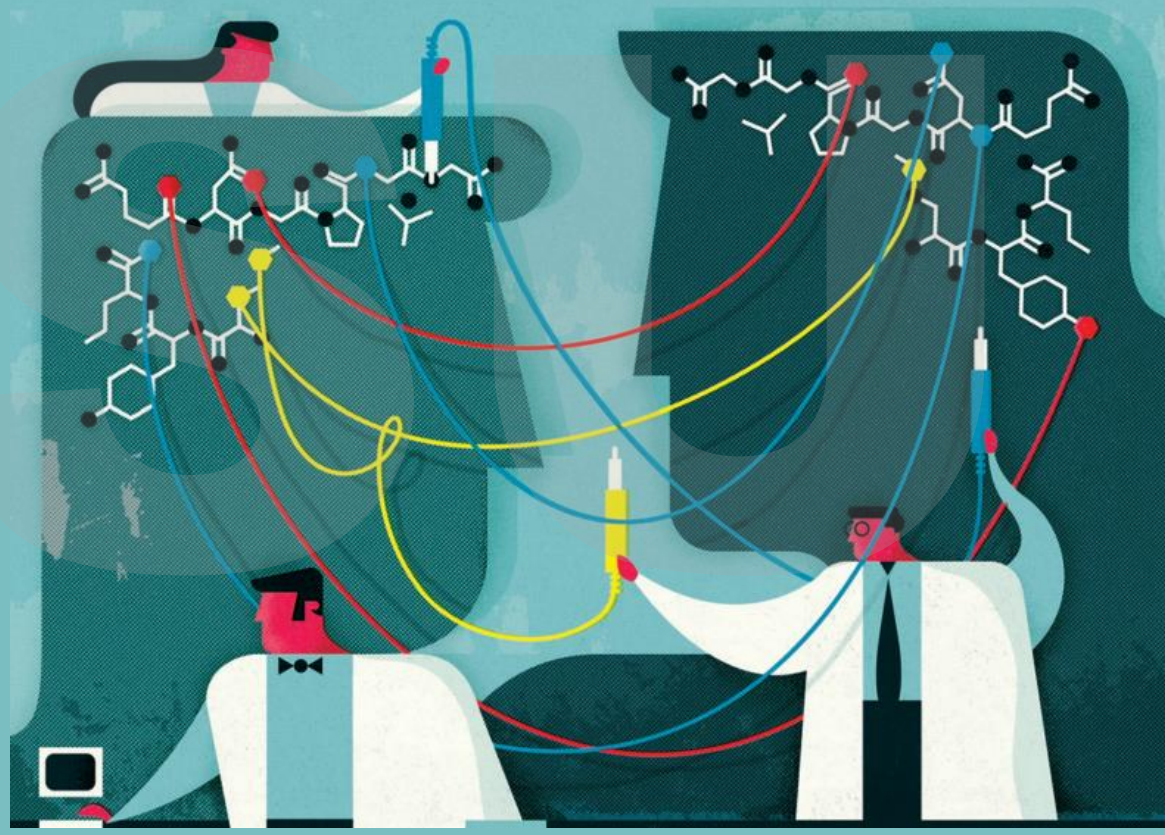
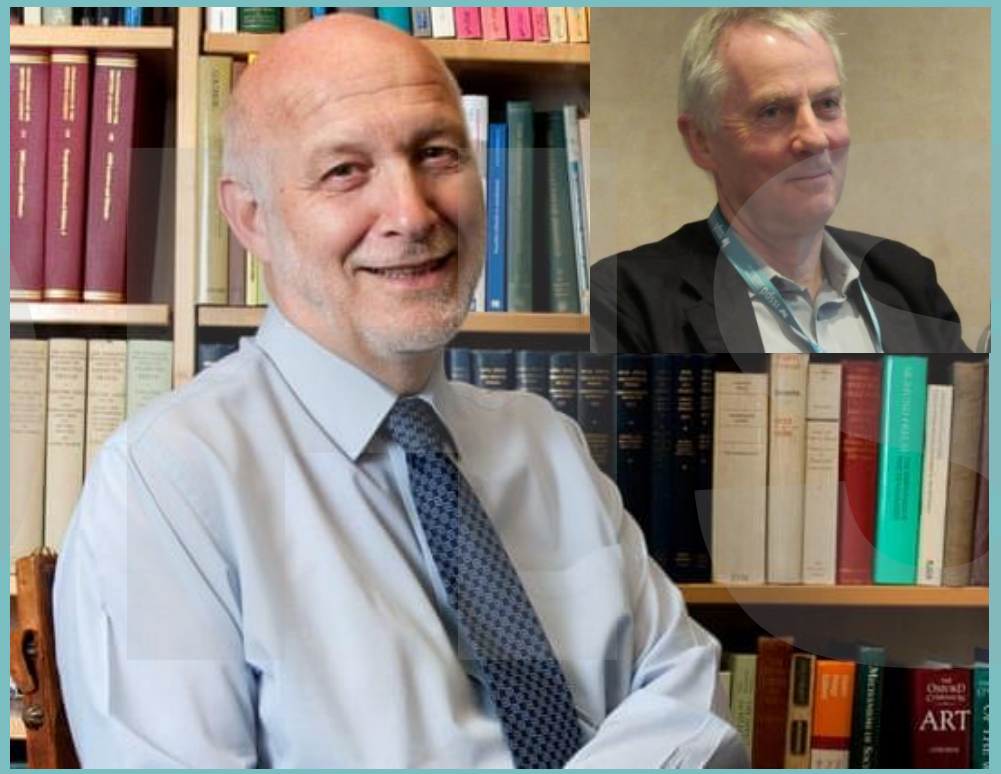
Objectives:

- Understand the internal experience of persons with BPD.
- Describe basic neurobiology findings in persons with BPD.
- Outline the most effective treatments for persons with BPD and comorbid psychiatric disorders.

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Setting the Scene:

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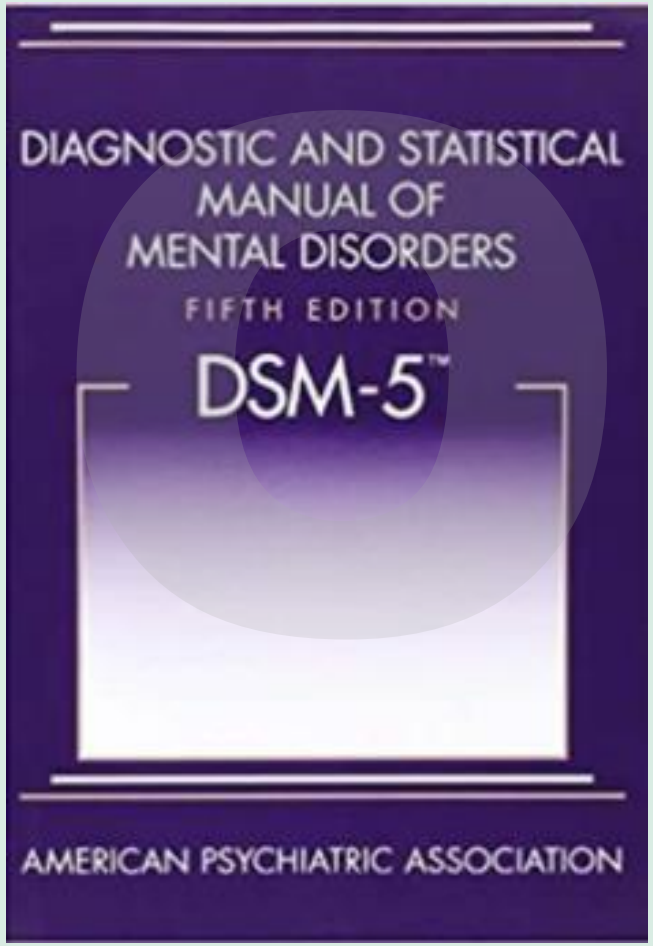
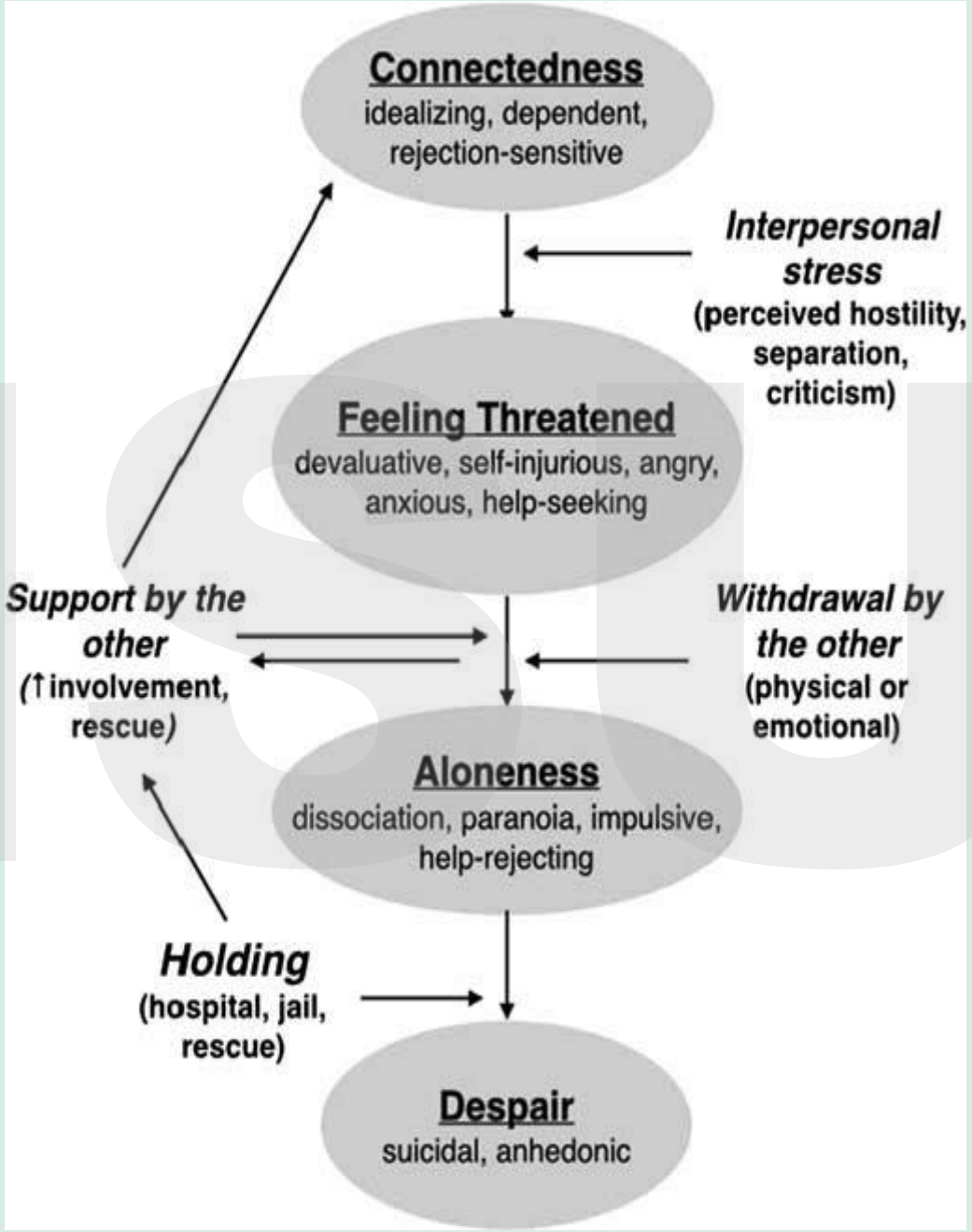


A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked instability, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Frantic efforts to avoid real or imagined abandonment
2. A pattern of unstable and intense interpersonal relationship characterized by extremes of idealization and devaluation
3. Identity disturbance: markedly and persistently unstable self-image or sense of self.
4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating, [does not include suicidal or self-mutilating behavior]).
5. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior.
6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and rarely more than a few days).
7. Chronic feelings of emptiness.
8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
9. Transient, stress-related paranoid ideation or severe dissociative symptoms.

Gunderson's Model of Interpersonal Coherence

"Interpersonal Sensitivity Disorder"



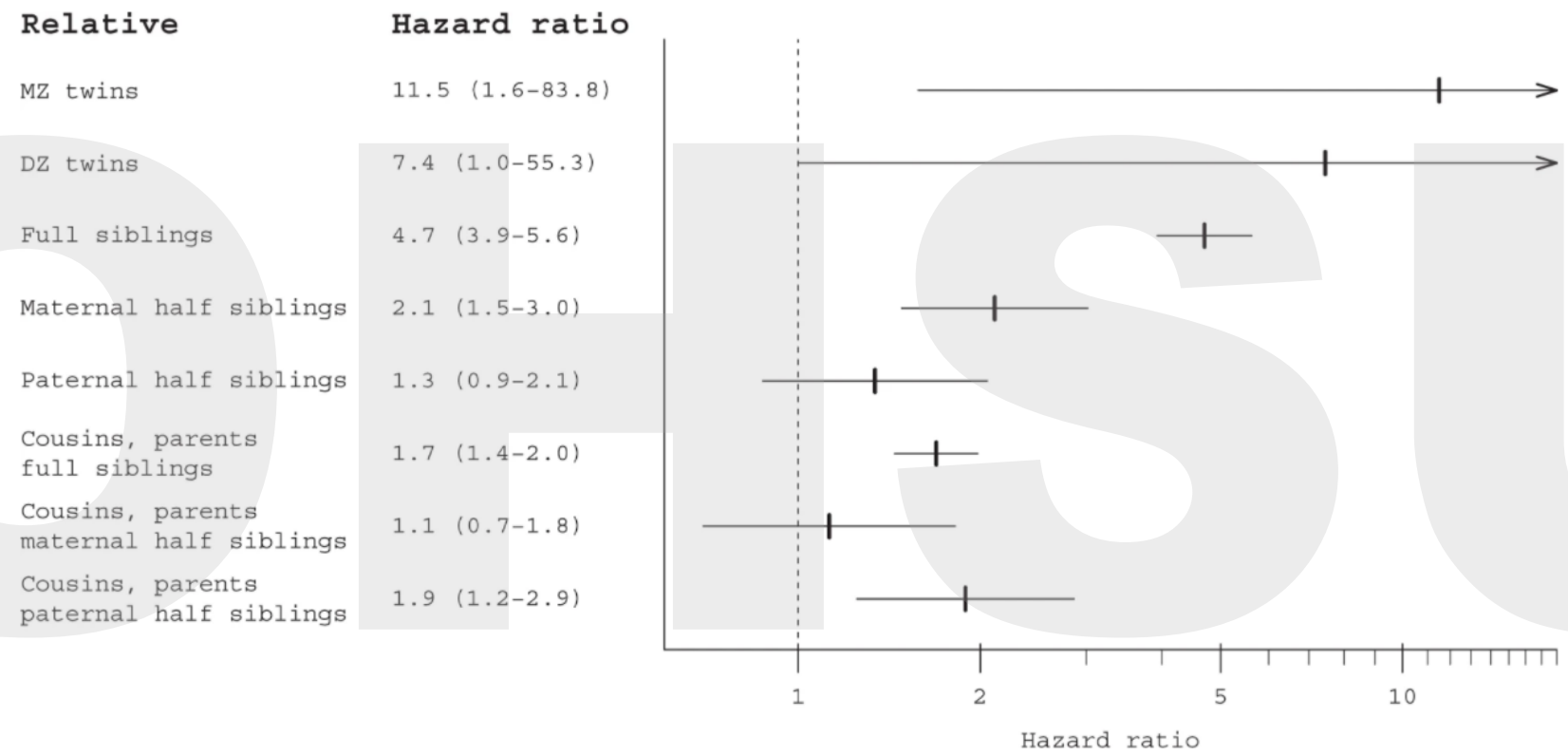
from Gunderson, JG and Links, PS. *Handbook of Good Psychiatric Management for Borderline Personality Disorder,* 2014

Inside:

I didn’t choose to have BPD,
I inherited it.

Fig. 2

From: Familial risk and heritability of diagnosed borderline personality disorder: a register study of the Swedish population

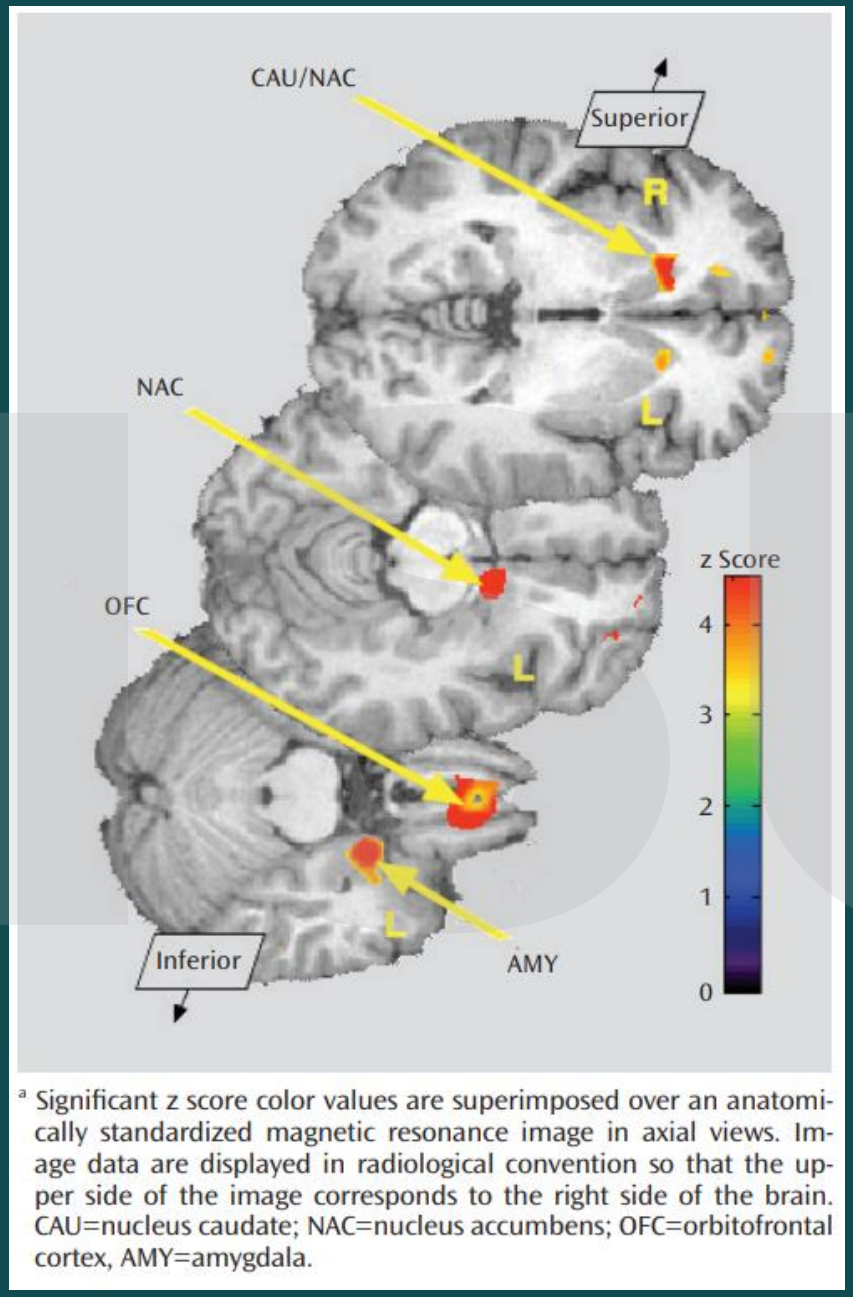


Familial aggregation. Hazard ratios (95% confidence interval). Note: X-axis uses logarithmic scale; plot with non-logarithmic scale can be found in Supplemental eFigure 2

Image from: Skoglund C, et al (2019). Familial risk and heritability of diagnosed borderline personality disorder: a register study of the Swedish population. Molecular Psychiatry 26, 999-1008.

My opioid system works differently.

Opioid Receptor Dysfunction



[a] Significant z score color values are superimposed over an anatomically standardized magnetic resonance image in axial views. Image data are displayed in radiological convention so that the upper side of the image corresponds to the right side of the brain. CAU=nucleus caudate; NAC=nucleus accumbens; OFC=orbitofrontal cortex, AMY=amygdala.

Image from: Prossin, A. R., Love, T. M., Koeppe, R. A., Zubieta, J.-K., & Silk, K. R. (2010). Dysregulation of regional endogenous opioid function in borderline personality disorder. *The American Journal of Psychiatry*, **167**(8), 925– 933.

My oxytocin system works differently.

Oxytocin Responsiveness to Social Exclusion

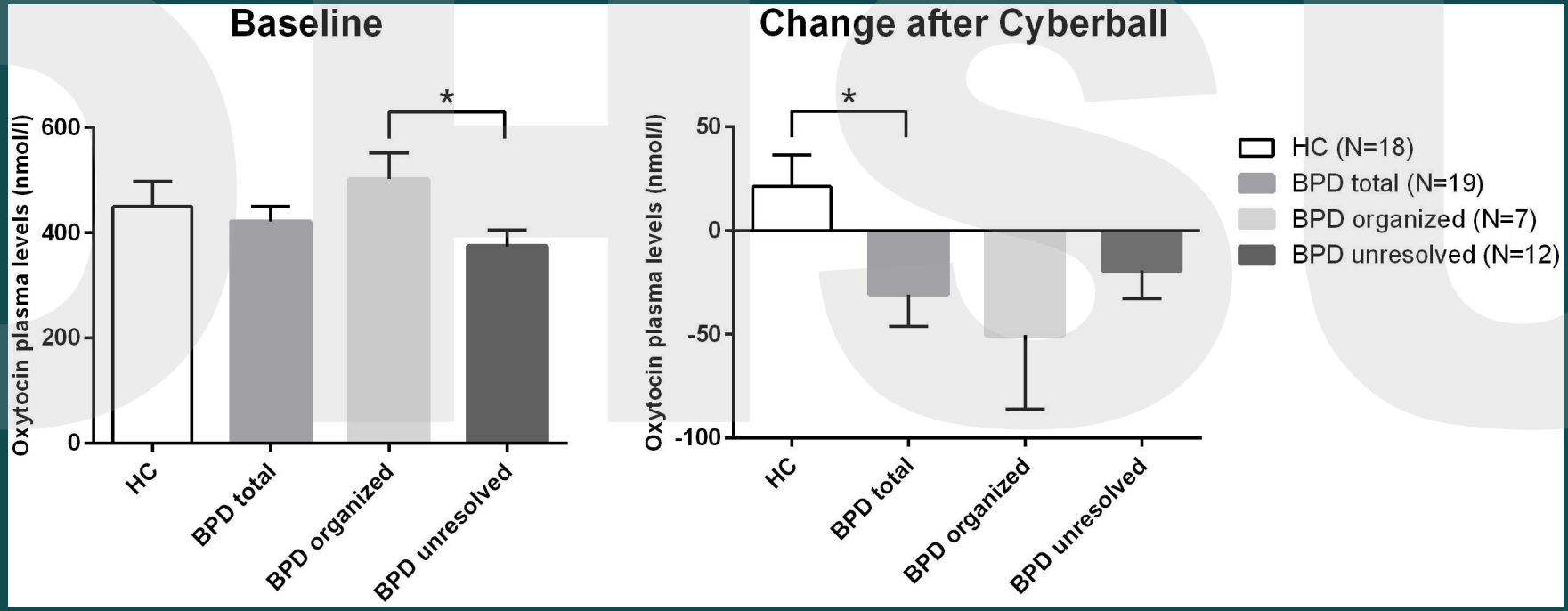
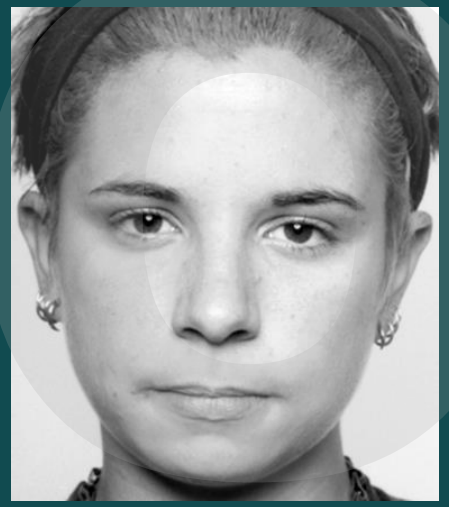


Image from: Jobst A, Padberg F, Mauer M-C, Daltrozzo T, Bauriedl-Schmidt C, Sabass L, Sarubin N, Falkai P, Renneberg B, Zill P, Gander M and Buchheim A (2016) Lower Oxytocin Plasma Levels in Borderline Patients with Unresolved Attachment Representations. *Front. Hum. Neurosci.* 10:125. doi: 10.3389/fnhum.2016.00125

I sense microexpressions really well.

But macroexpressions dysregulate me.



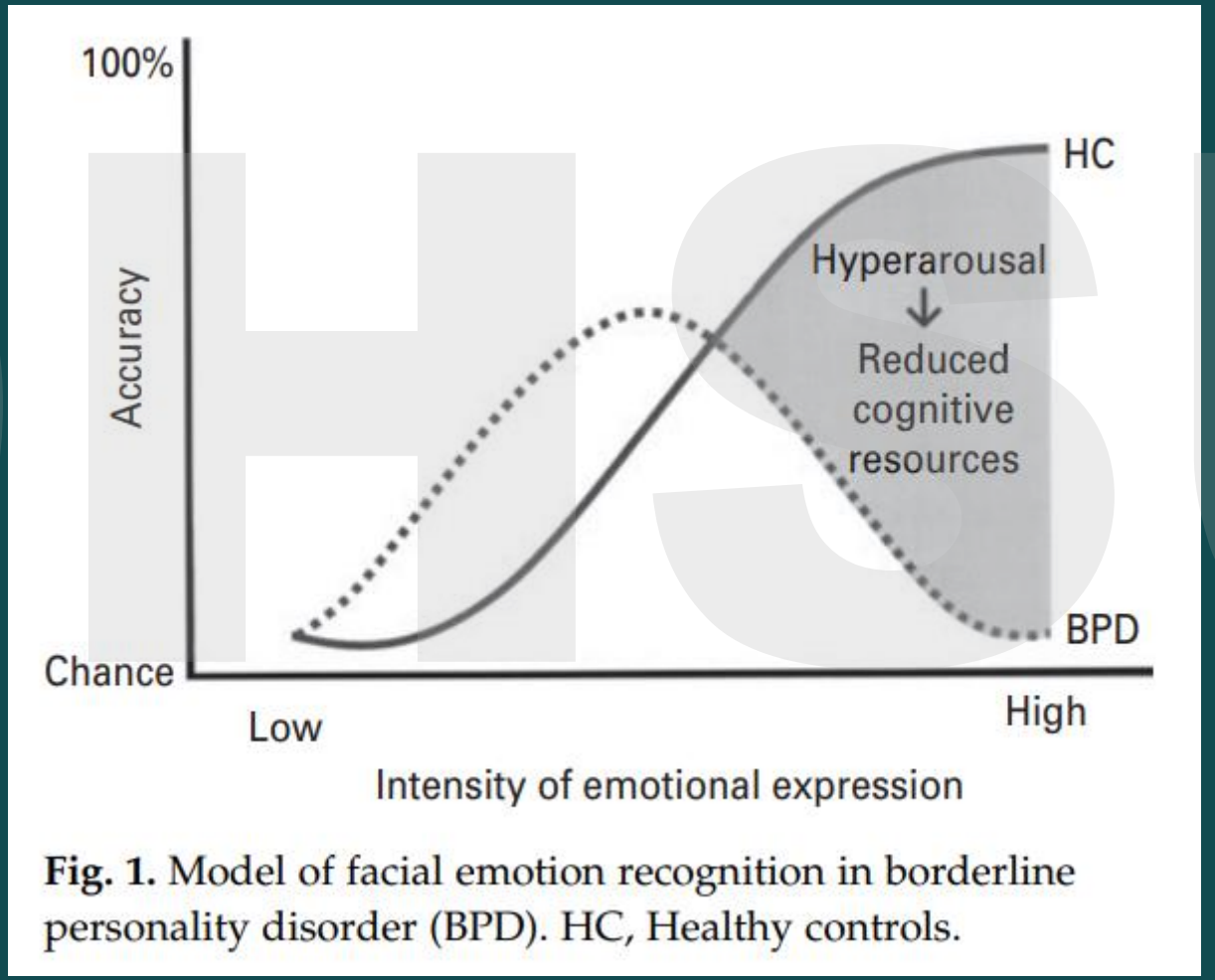


Fig. 1. Model of facial emotion recognition in borderline personality disorder (BPD). HC, Healthy controls.

Image from: Daros, A. R., Zakzanis, K. K., Ruocco, A. C. (2013). Facial emotion recognition in borderline personality disorder. Psychological Medicine, 43, 1953–1963.

I interpret neutral expression as angry.

Inside:

Reference: Domes G, Schulze L, Herpertz SC (2009) Emotion recognition in borderline personality disorder—a review of the literature. J Pers Disord. https://doi.org/10.1521/pedi.2009.23.1.6

I give too much to establish emotional connection, and then I have inappropriately high expectations that others will reciprocate.

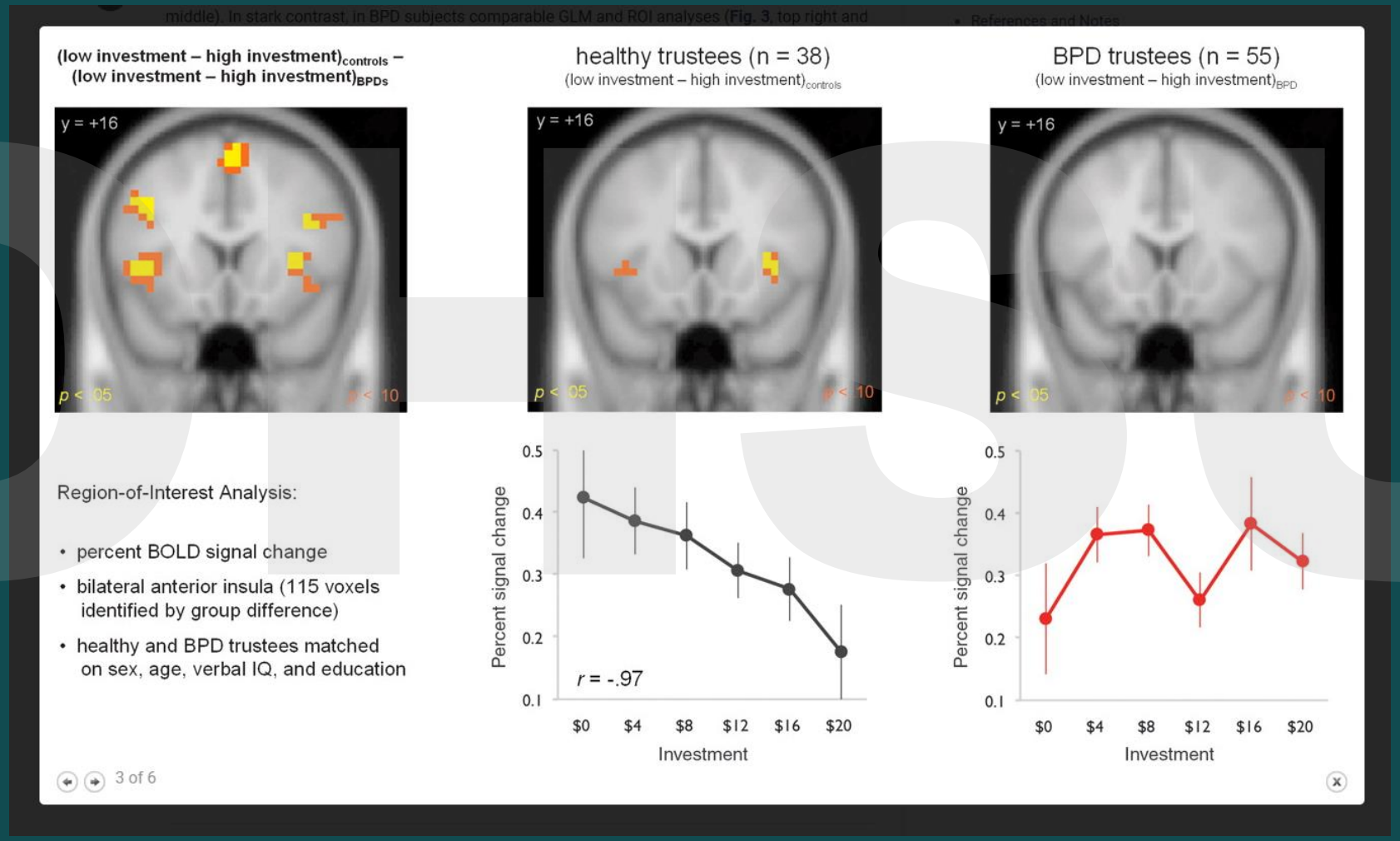


Image from: King-Casas B, Sharp C, Lomax-Bream L, Lohrenz T, Fonagy P, Read Montague P (2008). The Rupture and Repair of Cooperation in Borderline Peronsonality Disorder. *Science* Vol 321, pp 806-810.

I have experienced trauma…

Table 1. All random-effect meta-analyses of studies comparing BPD to non-clinical control groups

		OR (95% confidence interval)				Heterogeneity tests				Eggers test		
Adversity type	k	OR	Lower	Upper	*P*	I^2	*Q*	df	*P*	β	SE	*P*
Case-control studies												
Any adversity†	40	16.33	9.51	28.02	<0.001	98.34	2345.80	39	<0.001	7.45	0.65	<0.001
Any adversity‡	29	16.86	13.76	20.66	<0.001	54.81	61.96	28	<0.001	1.24	0.52	0.025
Any adversity§	36	13.91	11.11	17.43	<0.001							
Physical abuse†	30	6.82	4.90	9.50	<0.001	80.17	146.23	29	<0.001	3.11	0.89	0.002
Physical abuse‡	22	9.18	7.07	11.93	<0.001	36.22	32.93	21	0.05	1.86	0.67	0.012
Physical abuse§	23	7.06	5.26	9.48	<0.001							
Emotional abuse†	27	31.41	18.99	51.96	<0.001	88.49	225.92	26	<0.001	4.22	1.39	0.006
Emotional abuse‡	19	38.11	25.99	55.88	<0.001	63.09	48.77	18	<0.001	2.25	1.30	0.100
Sexual abuse†	33	6.60	5.15	8.47	<0.001	63.51	87.69	32	<0.001	2.19	0.69	0.003
Sexual abuse‡	30	6.76	5.41	8.44	<0.001	48.84	56.68	29	0.002	1.74	0.62	0.009
Sexual abuse§	35	5.96	4.72	7.52	<0.001							
Physical neglect†	21	7.97	5.21	12.19	<0.001	79.87	99.34	20	<0.001	1.28	1.22	0.306
Physical Neglect‡	15	7.61	5.74	10.11	<0.001	27.97	19.44	14	0.149	1.24	0.62	0.064
Physical neglect§	19	6.93	5.23	9.20	<0.001							
Emotional neglect†	26	22.97	15.02	35.15	<0.001	83.95	155.81	25	<0.001	2.93	1.33	0.037
Emotional Neglect‡	19	23.06	17.21	30.90	<0.001	48.73	35.11	18	0.009	2.06	0.81	0.022
Emotional neglect§	25	17.73	13.01	24.17	<0.001							
Epidemiology studies												
Any adversity†	2	2.56	1.24	5.30	0.011	59.87	2.49	1	0.114			
Physical abuse†	1	2.40	1.70	2.45	<0.001							
Emotional abuse†	1	2.31	1.87	2.86	<0.001							
Sexual abuse†	1	2.47	1.42	2.97	<0.001							
Prospective cohort studies												
Any abuse†	2	2.59	0.93	7.30	0.070	76.08	4.18	1	0.041			
Physical abuse†	1	2.09	1.71	2.44	<0.001							
Emotional abuse†	1	4.99	1.83	13.55	0.002							
Sexual abuse†	1	1.46	0.67	3.18	0.340							

k denotes all imputed and observed studies in the trim and fill analysis.
†Analysis of all relevant studies.
‡Analysis of all relevant studies, outliers removed.
§Analysis of all eligible studies with outliers removed trim and fill imputation for publication or selection bias.

Image from: Porter C et al, (2020). Childhood Adversity and borderline personality disorder: a meta-analysis. Acta Psychaitr Scand, 141, p.6-20.

…and my everyday social interactions continue to feel negative.

Table 5

Effect of PD Group on Perceptions of Emotional Reactions

						BPD		OPD		NOPD	
Emotion Factor Scores	**n**	**M**	**SD**	**b**	**SD**	**M**	**SD**	**M**	**SD**	**M**	**SD**
Anger											
Overall	1237	-.03	.06	.20*	.08	.19 a	.09	-.16 b	.09	-.16 b	.12
Romantic	158	.23	.16	.26	.19	.46 a	.26	.20 a	.27	-.05 a	.29
Family Member	202	.10	.11	.28*	.14	.45 a	.18	-.11 b	.17	-.29 a,b	.22
Friendship	183	-.15	.12	.12	.14	-.05 a	.18	-.14 a	.20	-.29 a	.22
Anxiety											
Overall	1237	.01	.06	.16*	.08	.15 a	.09	-.03 a,b	.09	-.17 b	.12
Romantic	158	-.07	.09	.14	.11	.02 a	.15	.02 a	.16	-.28 a	.17
Family Member	202	-.10	.09	-.01	.11	-.07 a	.15	-.16 a	.14	-.03 a	.17
Friendship	183	-.19	.09	.16	.11	-.02 a	.14	-.27 a	.16	-.34 a	.18
Positive											
Overall	1237	-.02	.06	-.16*	.07	-.14 a	.09	-.02 a,b	.08	.20 b	.12
Romantic	158	-.02	.11	-.13	.14	-.09 a	.18	-.13 a	.20	.19 a	.21
Family Member	202	-.09	.10	-.23 t	.12	-.31 a	.16	-.04 a,b	.15	.13 b	.19
Friendship	183	.27	.09	-.07	-.07	.22 a	.13	.25 a	.15	.37 a	.17
Emptiness											
Overall	1237	-.002	.06	.32**	.08	.35 a	.10	-.21 b	.10	-.22 b	.14
Romantic	158	-.004	.13	.43**	.15	.45 a	.20	-.16 b	.22	-.39 b	.22
Family Member	202	.02	.09	.30**	.11	.38 a	.14	-.18 b	.13	-.17 b	.17
Friendship	183	-.13	.10	.28*	.12	.19 a	.15	-.36 b	.17	-.33 b	.19
Sadness											
Overall	1237	-.01	.07	.21*	.08	.22 a	.10	-.15 b	.10	-.15 b	.14
Romantic	158	.14	.15	.19	.18	.38 a	.24	.01 a	.26	.02 a	.27
Family Member	202	.08	.09	.15	.12	.29 a	.16	-.08 a	.15	.03 a	.19
Friendship	183	-.06	.11	.04	.13	-.02 a	.17	-.07 a	.19	-.09 a	.21

Image from: Stepp, et al (2009). Interpersonal and Emotional Experiences of Social Interactions in Borderline Personality Disorder. J Nerv Ment Dis. 197, p484-491.

My frontal lobe doesn’t do a good job of controlling my amygdala…

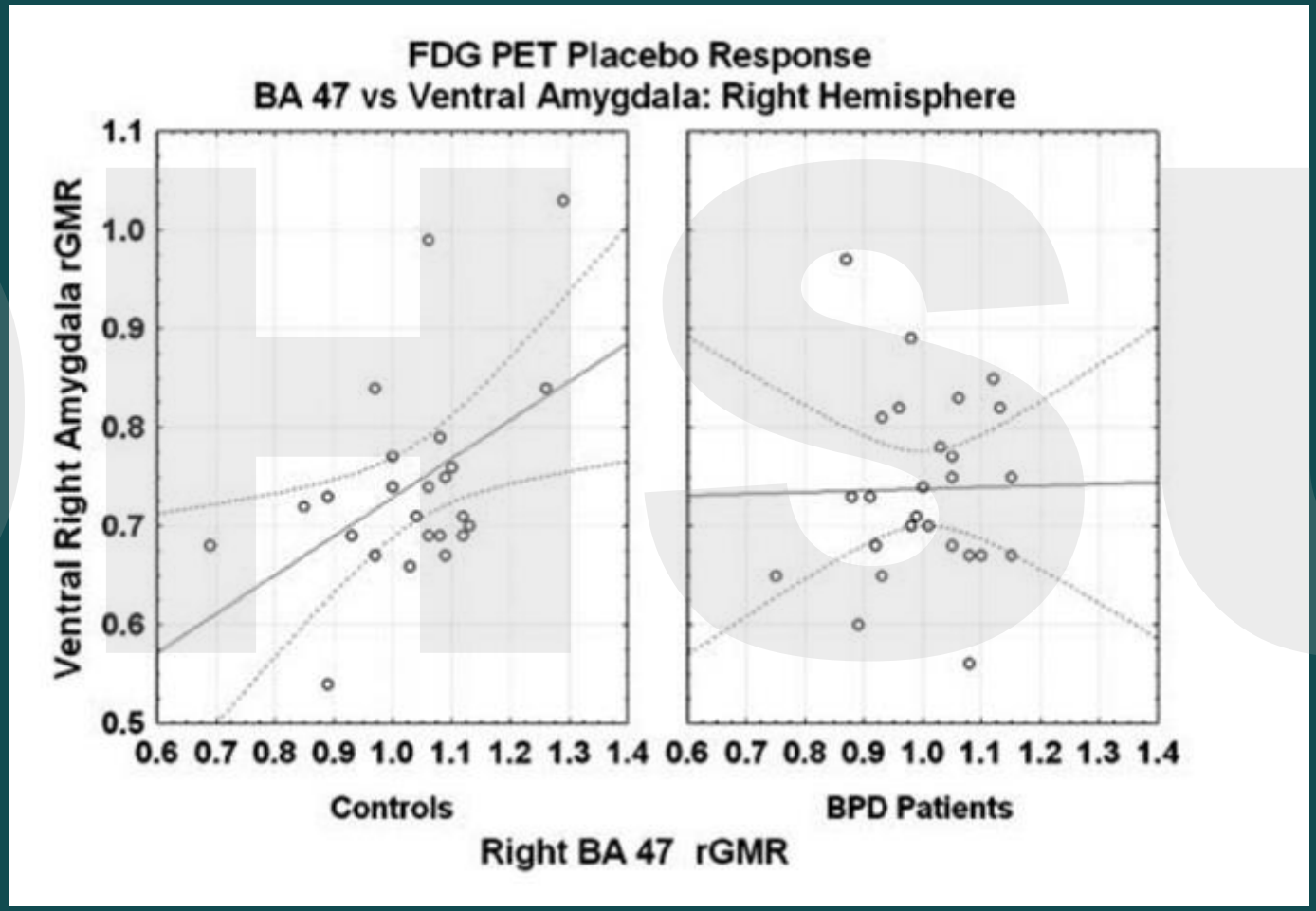


Image from: New A, et al (2007). Amygdala-Prefrontal Disconnection in Borderline Personality Disorder. Neuropsychopharmacology (2007) 32, 1629–1640

…but pain does.

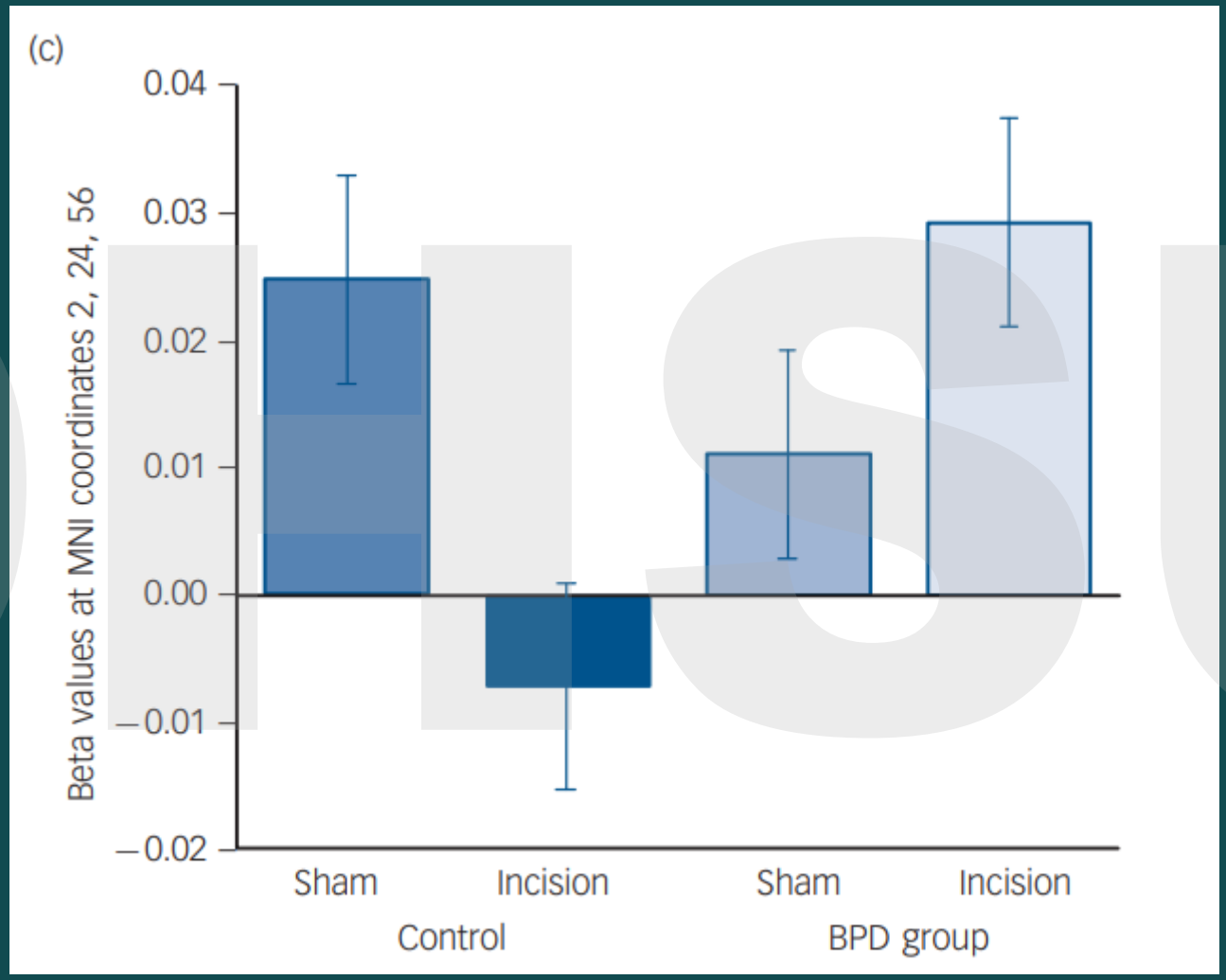


Image from: Reitz S, et al (2015). Incision and stress regulation in borderline personality disorder: neurobiological mechanisms of self-injurious behavior. BJPsych, 207, pp 165-172.

I want to feel better,
and I can get better.

TABLE 1. Cumulative Rates of Remission for Patients With Borderline Personality Disorder and Comparison Subjects With Other Axis II Disorders Over 16 Years of Prospective Follow-Up

	Follow-Up Evaluation and Remission Rate (%)							
Duration of Remission and Group	2-Year	4-Year	6-Year	8-Year	10-Year	12-Year	14-Year	16-Year
2 Years[a]								
Borderline personality disorder	35	55	76	88	91	95	97	99
Other personality disorder	88	96	99	99	99	99	99	99
4 Years[b]								
Borderline personality disorder		29	47	67	80	84	90	95
Other personality disorder		86	94	95	97	97	97	97
6 Years[c]								
Borderline personality disorder			28	44	63	78	82	90
Other personality disorder			86	94	95	97	97	97
8 Years[d]								
Borderline personality disorder				28	43	57	70	78
Other personality disorder				85	94	95	97	97

[a] Borderline personality disorder patients had a significantly slower time to remission (hazard ratio=0.15, 95% CI=0.08–0.26; z=–6.62, p<0.001).
[b] Borderline personality disorder patients had a significantly slower time to remission (hazard ratio=0.17, 95% CI=0.10–0.29; z=–6.72, p<0.001).
[c] Borderline personality disorder patients had a significantly slower time to remission (hazard ratio=0.15, 95% CI=0.09–0.25; z=–7.11, p<0.001).
[d] Borderline personality disorder patients had a significantly slower time to remission (hazard ratio=0.13, 95% CI=0.07–0.22; z=–7.40, p<0.001).

Image from: Zanarini, M. C., Frankenburg, F. R., Reich, D. B., & Fitzmaurice, G. (2012). Attainment and stability of sustained symptomatic remission and recovery among patients with borderline personality disorder and axis II comparison subjects: A 16-year prospective follow-up study. *American Journal of Psychiatry, 169*(5), 476–483

Inside:
The BPD brain…

1. Inherited it's challenges
2. Has opioid and oxytocin circuits that work differently
3. Has an easy time identifying subtle emotions, but gets hyperaroused and struggles with macroexpressions of emotion.
4. Interprets neutral faces as negative.
5. Has a hard time judging social reciprocity, and may lead to expectations that are inappropriate.
6. Is likely to report having experienced traumas, and continues to report many important intimate interactions in a negative light.
7. Has a frontal lobe that does a poor job of controlling the amygdala, unless it uses pain.
8. Knows it is suffering, wants to get better, and does.

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Outside:
The provider's task…

1. Avoid blame, acknowledge BPD may affect many family members.
2. Recognize limited effect of most psych meds and risk of opioid and other substance use disorders.
3. Stay regulated, contain anger or frustration.
4. Always lean in with some appropriate positive regard.
5. Overtly explain your thought process, not just your answers
6. Recognize that you will likely be thought of as the bad doctor at some point.
7. Recognize not all self-harm is suicidal, and that self-harm is often modulating internal sensations.
8. Help patients find good treatments.

1. Avoid blame
   - Allow patient to explore diagnosis and see if it fits.
   - Use McLean Screening Instrument for BPD or Gunderson Model of Interpersonal Coherence.

MacLean Screening Instrument for BPD

1.	Have any of your closest relationships been troubled by a lot of arguments or repeated breakups?	Yes____No____
2.	Have you deliberately hurt yourself physically (e.g., punched yourself, cut yourself, burned yourself)? How about made a suicide attempt?	Yes____No____
3.	Have you had at least two other problems with impulsivity (e.g., eating binges and spending sprees, drinking too much and verbal outbursts)?	Yes____No____
4.	Have you been extremely moody?	Yes____No____
5.	Have you felt very angry a lot of the time? How about often acted in an angry or sarcastic manner?	Yes____No____
6.	Have you often been distrustful of other people?	Yes____No____
7.	Have you frequently felt unreal or as if things around you were unreal?	Yes____No____
8.	Have you chronically felt empty?	Yes____No____
9.	Have you often felt that you had no idea of who you are or that you have no identity?	Yes____No____
10.	Have you made desperate efforts to avoid feeling abandoned or being abandoned (e.g., repeatedly called someone to reassure yourself that he or she still cared, begged them not to leave you, clung to them physically)?	Yes____No____

7 or higher indicates likelihood of meeting BPD criteria.

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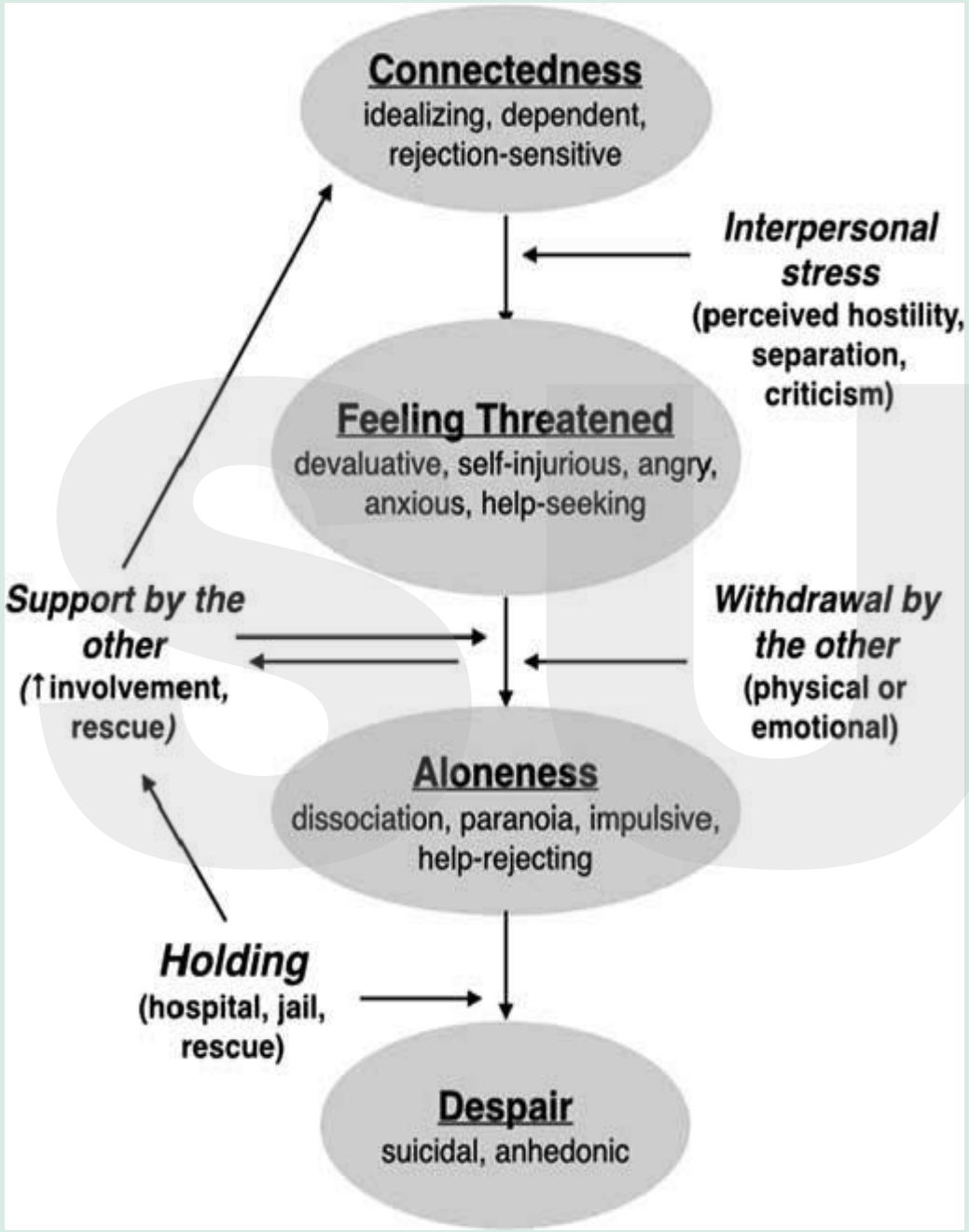
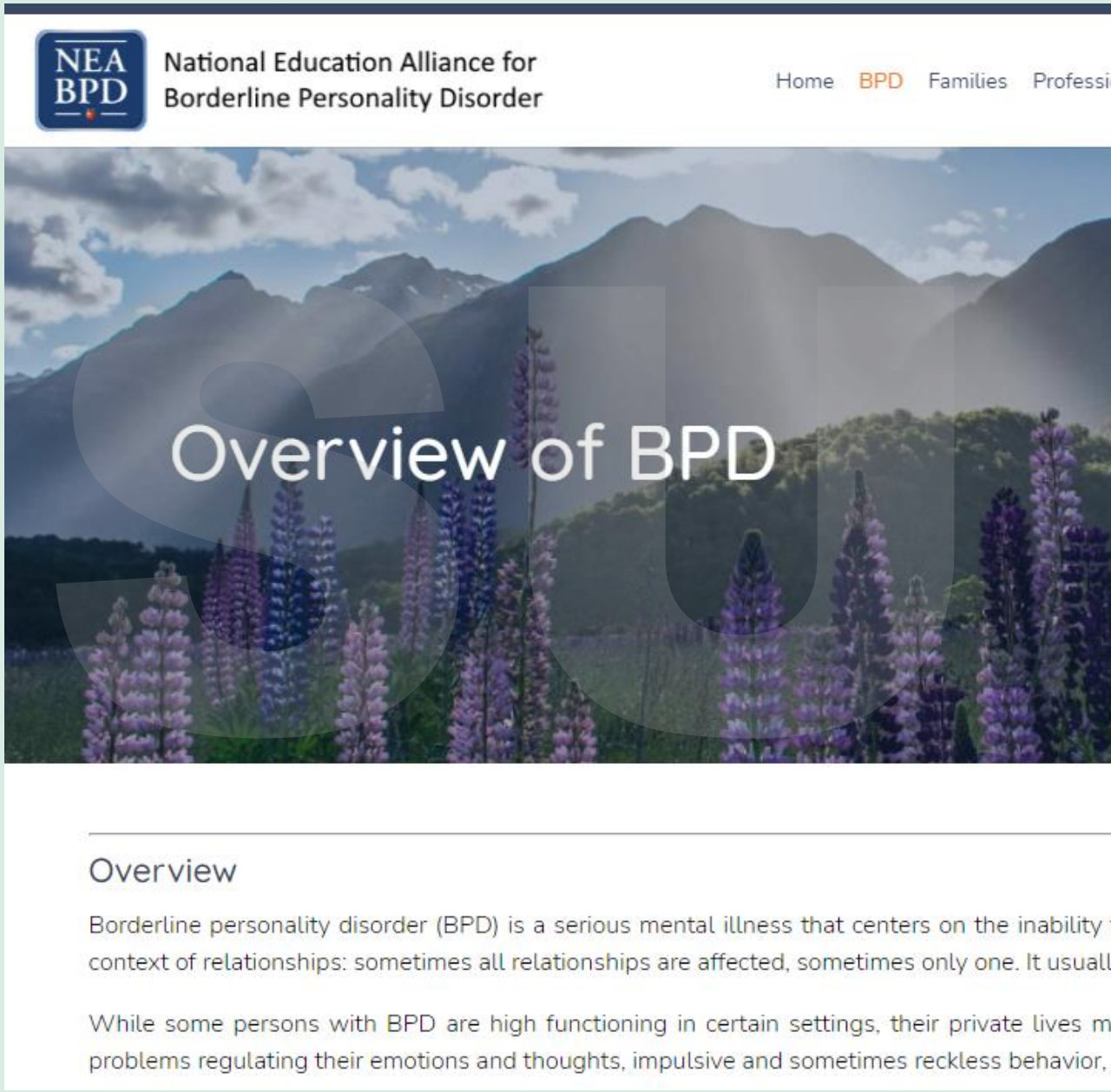
   - Allow patient to explore diagnosis and see if it fits.
   - Use McLean Screening Instrument for BPD or Gunderson Model of Interpersonal Coherence.



from Gunderson, JG and Links, PS. *Handbook of Good Psychiatric Management for Borderline Personality Disorder,* 2014

1. Avoid blame
    - Provide Psychoeducation to Patient
        - Heritability
        - Effective Treatments
        - Good Outcomes
    - Provide Psychoeducation to families.

Borderlinepersonalitydisorder.org



Tips for Families:

- *Go slowly: change is difficult to achieve and fraught with fears. Temper your expectations. Set realistic goals that are attainable.*

- *Be cautious/Keep things cool: avoid suggesting 'great progress' or 'you can do it' encouragement (progress evokes fears of abandonment); appreciation and disagreement are both normal – tone them down;*

- *Maintain family routines as much as possible : stay in touch with family and friends - there's more to life than problems.*

- *Find time to talk: Chats about light or neutral matters are helpful. Schedule time to do this.*

- *Manage Crises: Self-destructive acts require attention, but don't panic. Listen. Avoid defensiveness. Keep providers informed.*

2. Explain the limited effect of most psych meds and risk of opioid and other substance use disorders.

"When BPD is present with other disorders, BPD should almost always be treated as primary disorder – because improvement in BPD leads to improvement of other DOs. Sadly treating the other disorders as primary is often not effective when BPD is present."

	Comorbidities in patients with BPD
Major Depressive D/O	50%
Bipolar D/O (Type I and Type 2)	15%
Panic D/O	50%
Post-traumatic Stress Disorder	30%
Substance Use D/O, active	35%
Antisocial PD	25%
Narcissistic PD	15%
Eating Disorder	20%

2. Explain the limited effect of most psych meds and risk of opioid and other substance use disorders.

Disorder	Manage the BPD first?	
MDD, mild-mod MDD, severe	YES No	Will remit BPD does Unable to use BPD tx
Bipolar Disorder I, Not-Manic Bipolar Disorder II Bipolar Disorder I, Actively Manic/Depress	YES YES No	Recurrence ↓ if BPD remits Will remit if BPD does Unable to use BPD tx
Anxiety, Panic Disorders	YES	Will remit if BPD does
PTSD, Early onset, complex PTSD, Adult onset	No ?	Too vigilant to attach/tolerate challenge If able to use BPD tx
Substance Use DO, active	No	If 3-6 mo sober, may make BPD tx OK
Antisocial PD	?	Is treatment for secondary gain
Narcissistic PD	YES	Overall ↓response to BPD tx comp to others, but can improve
Anorexia/Bulimia, sev Anorexia/Bulimia, mild	No ?	Unable to use BPD tx If physical health stable, then OK to use BPD tx

Evidence-Based Treatments for BPD				
	Dialectical Behavioral Therapy	**Mentalization-based treatment**	**Transference-focused psychotherapy**	**General Psychiatric Management**
Description	Cognitive-Behavioral Therapy based. Didactically trains capacity to recognize and manage emotions in interpersonal situations. • Mindfulness • Distress tolerance • Emotion Regulation • Interpersonal Effectiveness	Psychoanalytically based. Promotes: • capacity to be aware of and think about oneself and others in terms of meaningful mental states. Therapist assumes curious stance of "not knowing" and models modulations of emotions with thoughts.	Psychoanalytically based. Promotes: • integration of object representation to stabilize unstable relationships and aggression.	Case management or generalist approach. Promotes: • Acceptance of diagnosis • Understanding course • Practical focus on realistic focus on stressors. • Family Education and interventions to support patient growth.
Group Therapy	Essential	Essential	None	Encouraged
Individual	Once weekly	Once weekly	Twice weekly	Once weekly/PRN
Family Therapy	Family Connections	MBT-Family, Multi-family group therapy	None	Family Psychoeducation

Med type	Mood Instability	Depression	Anxiety	Anger	Impulsivity	Cognitive /Perceptual
SSRIs	?	+	?	?	+	-
TCAs	-	-	-	+	?	-
Mood Stabilizers	+	?/+	?	++	++	-
Antipsychotics	+	?	+	+	+	++
Anxiolytics	?	-	?	-	-	?

Medications may in some patients assist with associated symptoms, but don't promote remission of BPD

3. Stay regulated, contain anger or frustration.

4. Always lean in with some appropriate positive regard.

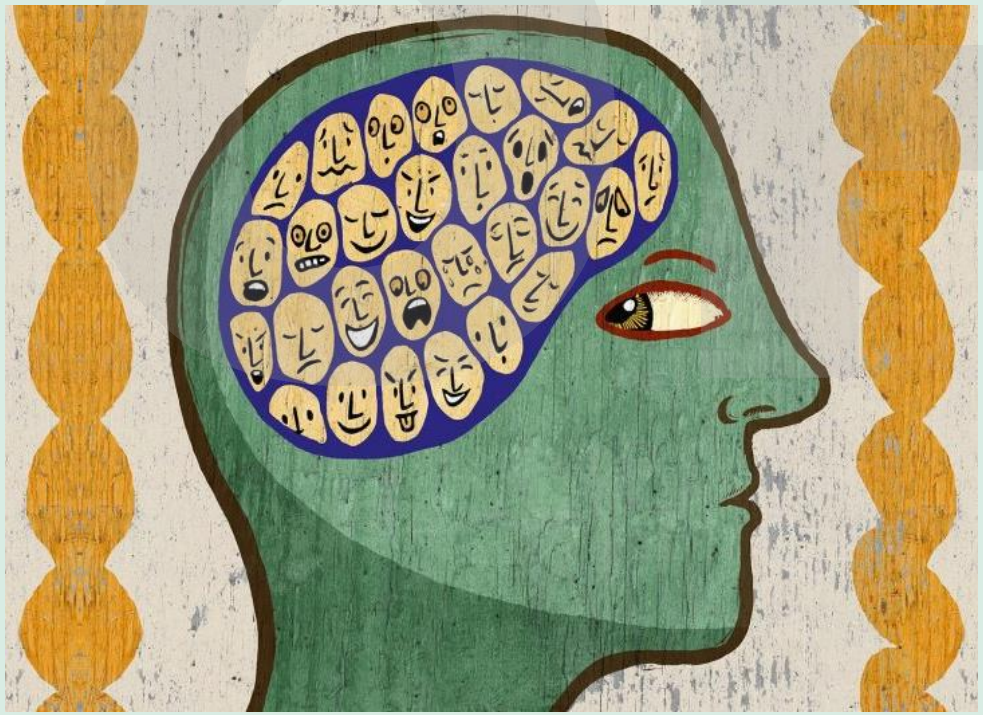
Gunderson's Principles (extracted):

1. **Be active, not reactive** *(model emotions with a contained, active mind)*
2. **Be thoughtful** *(model use of frontal lobes)*
3. **The relationship is real and professional** *(like the patient as a person, be genuine, remain the doctor.)*
4. **Be Flexible, Pragmatic, and eclectic** *(model flexibility and learning over time)*

from Gunderson, JG and Links, PS. *Handbook of Good Psychiatric Management for Borderline Personality Disorder,* 2014

If you're getting dysregulated, find a colleague who can help provide perspective and re-orient to caring.

5. Overtly explain your thought processes, not just your answers.

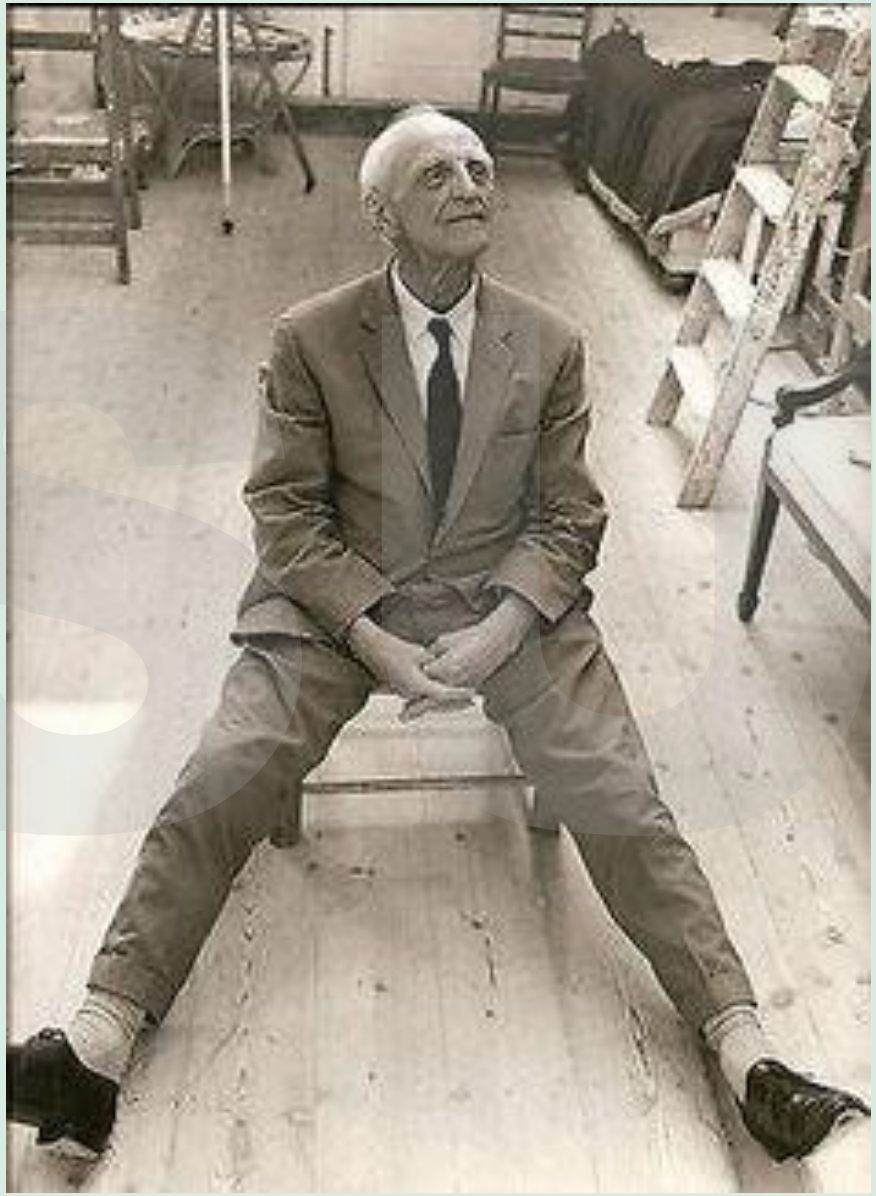


"I'm sorry you're suffering. It sounds like there is a part of you that really feels a medication would fix the pain you're experiencing now, and maybe another part that realizes that its not just your body hurting after some of the things you've experienced. As your doctor, part of me wants to make you feel better quickly, but I also wonder if just prescribing a medication is overlooking other parts of you that are suffering and that may be harmed further by giving you a medication that could contribute to dependence. These are tough decisions, and there may not be a perfect answer, but I want to make sure we consider the effects of my recommendations on all aspects of who you are: father, employee, friend, person in recovery, in addition to a patient with pain. How should we take all those parts of you into account in helping get you through this tough period?"

"I'm willing to hospitalize you despite my concern that it will not be helpful. I would do this because I fear you will become more suicidal if I do not. Am I right about that? We would both be better if we could find an alternative, yes?"

6. Recognize that you will likely be thought of as the bad doctor at some point.

- Focus on being the “good enough doctor”, not the perfect doctor.
  - Available
    - Be a secure base (don’t abandon)
    - Be a resource (for knowledge)
  - Responsive
    - Care (don’t dismiss)
    - Respond (within clearly explained parameters and channels)
  - Engaged
    - Be flexible in ideas (but have boundaries)
    - Seek to repair misunderstandings (but only rationally)



6. Recognize that you will likely be thought of as the bad doctor at some point.

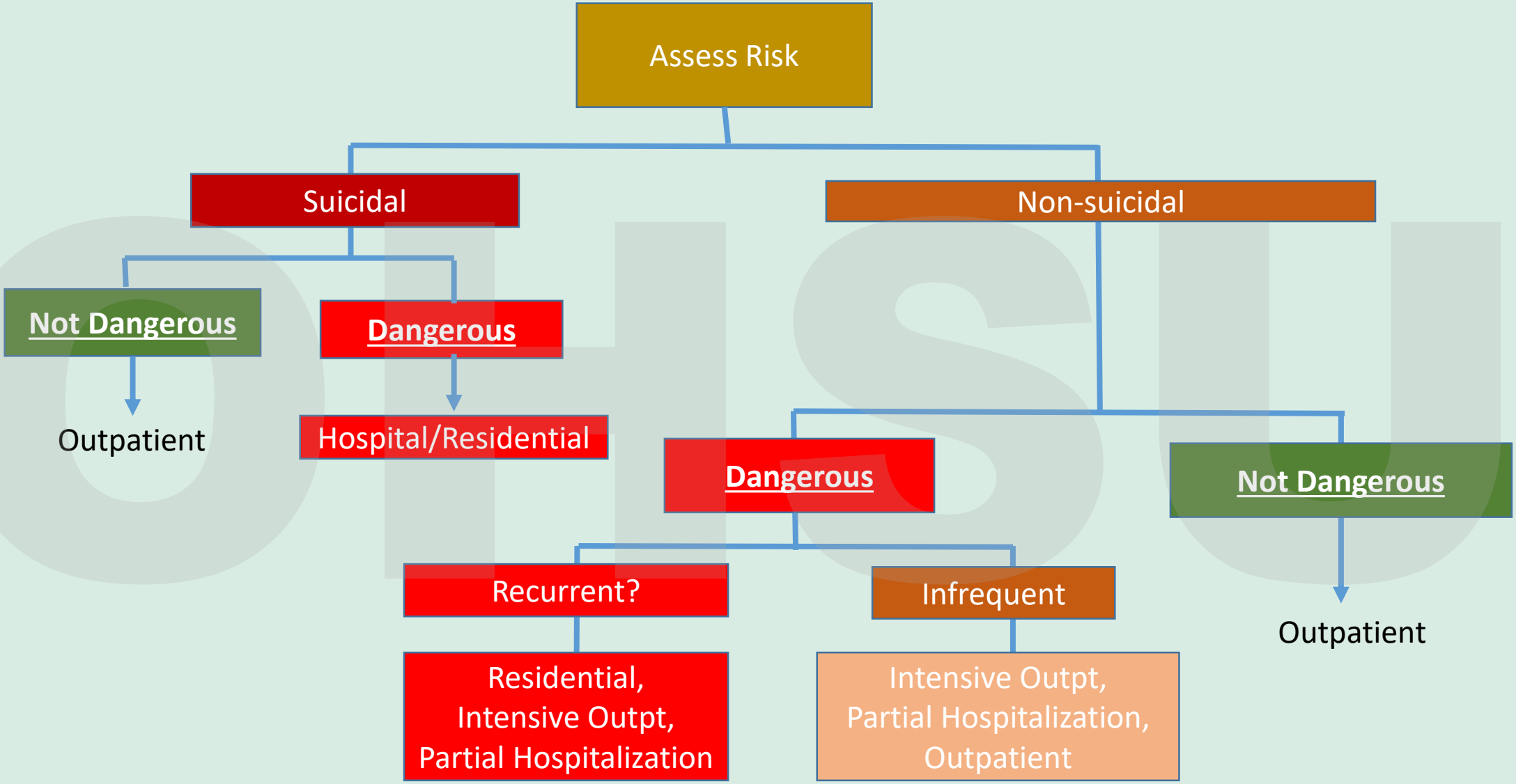
If the patient is splitting the team (one provider good, another provider bad)…

- get the team together
- process what is happening and why
- establish team boundaries that everyone shares (no mixed messages for the patient)
- express value for all the members of the team, even if skillsets vary – everyone is “good enough”.

7. Recognize not all self-harm is suicidal.

Become comfortable asking about non-suicidal self-injury (NSSI) and related feelings.

"I know that some people who experience stressors similar to yours think about hurting themselves on purpose without intending suicide. Have you ever hurt yourself without intending to end your life or attempt suicide? Like cutting, biting, burning, or hitting? Can you tell me what your mind is feeling and thinking prior to hurting yourself?"



Adapted from Gunderson, JG and Links, PS. *Handbook of Good Psychiatric Management for Borderline Personality Disorder,* 2014.

8. Help patients find good treatments.

Step	Severity	Definition	Potential Interventions	Intensity
Pre-Clinical	Subthreshold	Less self-harm Less suicidality	Psychoeducation supportive counseling	-
Early/Mild/ Intermittent	1st episode of BPD	Minimal self-harm Less suicidality	Psychiatrist GPM DBT skills group	↑
Sustained Moderate	Sustained threshold level sx	More self-harm Unresponsive to basic tx	Psychiatrist GPM + DBT skills training Single model EBT (DBT, MBT, TFP)	↑↑
Severe	Chronic Remitting and Relapsing	Severe self-harm Potentially Fatal Suicide attempts	Higher level of care (IOP, PH, Hosp) if needed Integration of EBTs	↑↑↑
Chronic Persistent	Unremitting	Unresponsive to interventions from previous stages	Psychiatrist GPM Supportive Therapy	↓ care to ↑ response?

Adapted from Gunderson, JG and Links, PS. *Handbook of Good Psychiatric Management for Borderline Personality Disorder,* 2014

8. Help patients find good treatments.

Individual therapists who do DBT/MBT

- Psychology Today Therapist Finder - https://www.psychologytoday.com/us/therapists
- Portland Psychotherapy Center - https://www.portlandtherapycenter.com/therapists

Therapy groups:

- The DBT Clinic (incl skills group) - http://www.thedbtclinicportland.com/
- Northwest DBT - https://northwestdbtpdx.com/
- Abri Radically Open DBT - https://abriradicallyopendbt.com/
- Portland Psychotherapy - https://portlandpsychotherapy.com/

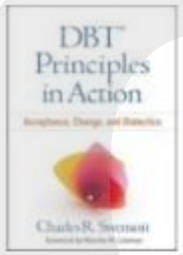
Programs/Intensive Outpatient

- Portland DBT Institute - https://www.pdbti.org/
- Providence IOP - https://oregon.providence.org/our-services/p/providence-psychiatric-dialectical-behavior-outpatient-therapy-program/

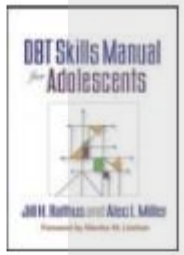
8. Help patients find good treatments.

Learn more yourself:

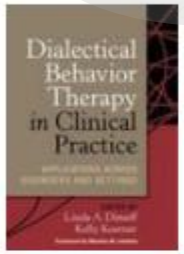
NEA BPD National Education Alliance for Borderline Personality Disorder



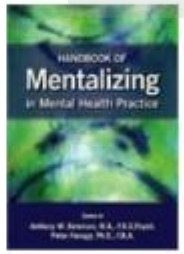
DBT® Principles in Action Acceptance, Change, and Dialectics Charles R. Swenson. New York, Guilford Press, 2016



DBT® Skills Manual for Adolescents Jill H. Rathus and Alec L. Miller New York, Guilford Press, 2014



Dialectical Behavior Therapy in Clinical Practice Applications across Disorders and Settings Edited by Linda A. Dimeff and Kelly Koerner; New York, Guilford Press, 2007



Handbook of Mentalizing in Mental Health Practice. Washington, DC: American Psychiatric Pub. 2012.

Psychotherapy for Borderline Personality Disorder: Mentalization-based

The High-conflict Couple: A Dialectical Behavior Therapy Guide to Finding Peace,

Portland DBT INSTITUTE

DBT Training Calendar
https://www.pdbti.org/dbt-training/

Behavioral Tech
A Linehan Institute Training Company

Linehan Institute Trainings
https://behavioraltech.org/events/

McLean
HARVARD MEDICAL SCHOOL AFFILIATE

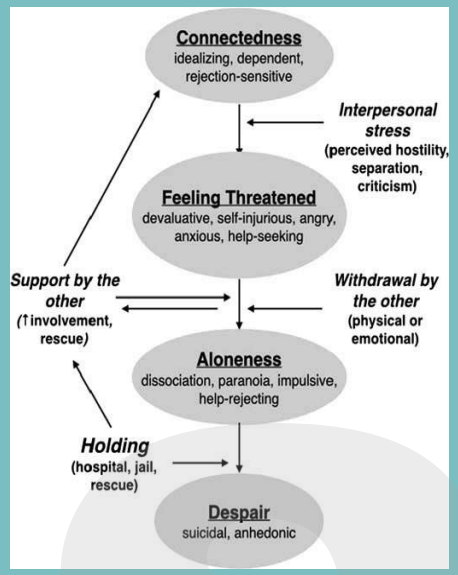
McLean Gunderson Institute Trainings
https://www.mcleanhospital.org/training/gunderson-institute

Anna Freud
National Centre for
Children and Families

Anna Freud Center - London
https://www.annafreud.org/training/mentalization-based-treatment-training/

Objectives:

- Understand the internal experience of persons with BPD.
- Describe basic neurobiology findings in persons with BPD.
- Outline the most effective treatments for persons with BPD and comorbid psychiatric disorders.



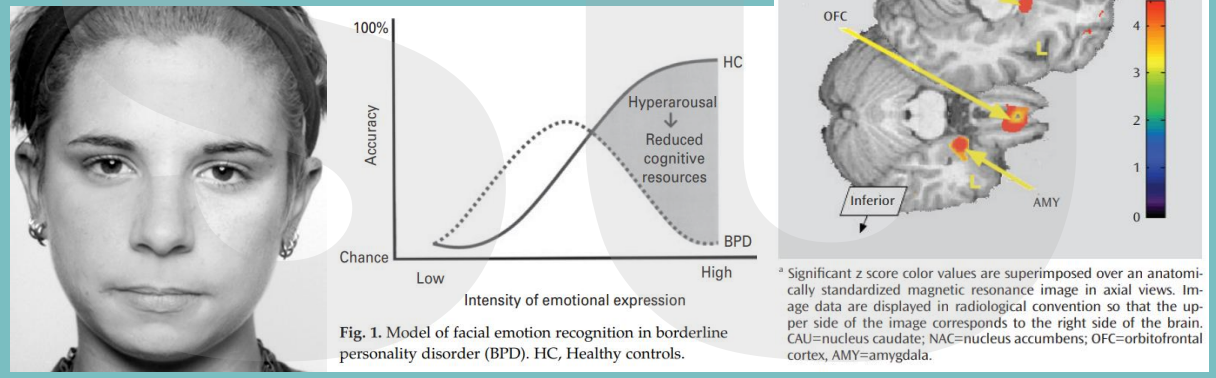


Fig. 1. Model of facial emotion recognition in borderline personality disorder (BPD). HC, Healthy controls.

[a] Significant z score color values are superimposed over an anatomically standardized magnetic resonance image in axial views. Image data are displayed in radiological convention so that the upper side of the image corresponds to the right side of the brain. CAU=nucleus caudate; NAC=nucleus accumbens; OFC=orbitofrontal cortex, AMY=amygdala.

Disorder	Manage the BPD first?	
MDD, mild-mod	YES	Will remit BPD does
MDD, severe	No	Unable to use BPD tx

Evidence-Based Treatments for BPD			
Dialectical Behavioral Therapy	Mentalization-based treatment	Transference-focused psychotherapy	General Psychiatric Management

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