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Editorial

# Borderline Personality Disorder: Research and Clinical Progress and Progress to be made

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## Editorial

Borderline personality disorder was described in early psychoanalysis reports of therapy. The idea of borderline disorder was further extended at Menniger Clinic when a patient developed some psychotic symptoms at the end of an analytic session [1]. The further experience of the borderline experiences in analytic treatment leads to an excellent formulation of how it developed early in life, what was the phenomenon and how to address the therapy [2]. During the 1970's there were substantial descriptions of not just dynamics in therapy, but a development of specific symptoms of the patients that were objective, such as history of impulsive behavior and brief psychotic experiences. This original article became the criteria for the Axis II section of the Diagnostic and Statistical Manual III [3].

With objective criteria that was in DSM III, and a questionnaire leading to consistent diagnosis [4], there were academic faculty who initiated clinical trials that were double-blind and placebo controlled for the first time [5,6]. These showed responsiveness to low doses of antipsychotic medications with Goldberg and colleagues clearly describing domains of the illness – such as ideas of reference and phobic anxiety. Soloff and colleagues in their study clearly showed decrease in symptoms on inpatient subjects for those given haloperidol, but not the anti-depressant.

After the development of second-generation antipsychotic medication, low-dose atypical antipsychotics were tested with some positive trials of olanzapine [7] and risperidone [8]. This work lead to increased research focusing on BPD and showing results positive and close to positive further in low-dose atypical anti-psychotic medications [9,10]. The protocols generally showed decreased symptoms using low-dose medications. Anticonvulsant medications which reduced different domains that was a major issue of using medications in BPD. The early studies noted significant impact on impulsivity and aggression with divalproex [11] and then other anticonvulsant medications were tested showing impact on aggression with lamotrigine [12] and then a comprehensive review that reported different domains noting impact of anticonvulsants [13].

Beyond these neuroscience studies, the focus on BPD lead to emerging new treatments of which some are substantially structured – Dialectical Behavioral Therapy (DBT), [14] and Systems Training for Emotional Predictability and Problem Solving (STEPPS), [15] while other continued dynamic and analytic approach [16-18]. The article by Gunderson shows the usefulness of each of these treatments and described the approaches currently.

Further, there has been a substantial study of dynamic MRI which has explored and discovered differences from controls in findings and correlations with certain symptoms [19]. This illustrates the neuro-dynamic background of BPD symptoms.

Currently, there are growths in research and low levels of metabolism in the frontal part of the brain associated with impulsivity [20]. This then lead to further research examining dopamine and PET scan study noting lower frontal metabolism in frontal-temporal lobes for example correlated with Buss-Durkee Hostility Index (BDHI) [21].

Also organizations are supporting treatment that is positive in this area. Yet there are concerns about these patients that need to be made clear and open to advance the knowledge and care for BPD. Certainly, a recent NIH project of more than 30,000 subjects has now clarified that 5% of Americans have BPD – not 1% [22]. This clearly points to the need for much more programs and clinicians.

Another area of the field for engagement is that some clinicians are criticizing medication treatment [23]. On the other hand, the largest studies are noting that 70-90% of BPD research subjects are taking medication for 1-2 years [14,15], however, not a report of the impact of medications.

Regarding research, there are issues that have not been approached even though it is important to be done. There are only three studies in the world testing the usefulness of psychosocial treatment (DBT) and medication [24-26]. One of the studies is positive and of substantial size looking at DBT and olanzapine [25] while there is the data showing DBT and fluoxetine is no better than DBT alone [24]. This needs to be advanced for patient care for a full team approach.

In another area, comments by Tohen [27] notes that the clinical research studies are so focused that there is not data on how to approach BPD with a co-morbid personality disorder or other issues that BPD patients have which is quite common. This is an important step to clarify complex BPD issues.

As noted, there are imaging studies exploring domains of BPD [28], but much more needs to be done in order to understand treatment based on the domains within the illness. With this data a full evaluation the treatment can match the domains.

Another area for study in BPD to advance knowledge in the field is to note the FIRST study [29] which has explored several approaches – therapy, medication, family therapy, and job training. The STEPP program has described a multidisciplinary program and this can be applied [15]. This is much more successful than just individual clinic visits for the BPD patients with difficult functions.




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## Conclusion

A number of academicians and community organizations have worked very hard to advance approaches to treatment, but support by NIH to advance the proof of care such as DBT and STEPPS, to understand medication treatment for domains as well as with focused psychosocial treatment is a crucial step. The need to perform neuroscience research to understand the physiology and the domains of BPD is crucial as the field has noted the heterogeneity and co-morbid issues.

### References

1. Mack JE. Borderline States in Psychiatry: An Historic Perspective. In New York, Grune & Stratton Inc. 1975; 1-27.
2. Kernberg O. Borderline personality organization. J Am Psycho anal Assoc. 1967; 15: 641-685.
3. Gunderson JG, Singer MT. Defining borderline patients: An overview. Am J Psychiatry. 1975; 132: 1-10.
4. Kolb J, Gunderson JG. Diagnosing borderline patients with a semi-structured interview. Arch Gen Psychiatry. 1980; 37: 37-40.
5. Goldberg SC, Schulz SC, Schulz PM, Resnick RJ, Hamer RM, Friedel RO. Borderline and Schizotypal Personality Disorders Treated With Low-Dose Thiothixene *vs.* Placebo. Arch Gen Psychiatry. 1986; 43:680-686.
6. Soloff PH, George A, Nathan RS, Schulz PM, Ulrich RF, Perel JM. Progress in pharmacotherapy of borderline disorders. A double-blind study of amitriptyline, haloperidol and placebo. Arch Gen Psychiatry. 1986; 43: 691-697.
7. Bogenschutz MP, George NH. Olanzapine versus placebo in the treatment of borderline personality disorder. J Clin Psychiatry. 2005; 65: 104-109.
8. Rocca P, Marchiaro L, Cocuzza F, Bogetto F. Treatment of personality disorder with risperidone. J Clin Psychiatry. 2002; 63: 241.
9. Schulz SC, Zanarini MC, Bateman A, Bohus M, Detke HC, Trzaskoma Q, et al. Olanzapine for the treatment of borderline personality disorder: variable dose 12-week randomized double-blind placebo-controlled study. British Journal of Psychiatry. 2008; 193: 485-492.
10. Zanarini MC, Schulz SC, Detke HC, Tanaka Y, Zhao F, Lin D, et al. A dose comparison of olanzapine for the treatment of borderline personality disorder: a 12-week randomized, double-blind, placebo-controlled study. J Clin Psychiatry. 2011; 72: 1353-1362.
11. Hollander E, Swann AC, Cocarro EF, Jang P, Smith TB. Impact of trait impulsivity and state aggression on divalproex versus placebo response in borderline personality disorder. Am J Psychiatry. 2005; 162: 621-624.
12. Leiberich P, Nickel MK, Tritt K, Pedrosa GF. Lamotrigene treatment of aggression in female borderline patients, Part II: an 18-month follow-up. J Psychopharmacol. 2008; 22: 805-808.
13. Vita A, De Peri L, Sacchetti E. Antipsychotics, antidepressants, anticonvulsants, and placebo on the symptom dimensions of borderline personality disorder: a meta-analysis of randomized controlled and open-label trials. J Clin Psychopharmacol. 2011; 31: 612-624.
14. Linehan MM, Comtois KA, Murray AM, Brown MZ, Gallop RJ, Heard HL, et al. Two-Year Randomized Controlled Trial and Follow-up of Dialectical Behavior Therapy *vs.* Therapy by Experts for Suicidal Behaviors and Borderline Personality Disorder. Arch Gen Psychiatry. 2006; 63: 757-766.
15. Blum N, John D, Fohl BP, Stuart S, McCormick B, Allen J. Systems Training for Emotional Predictability and Problem Solving (STEPPS) for Outpatients with Personality Disorder: A Randomized Controlled Trial and One-Year Follow-Up. Am J Psychiatry. 2008; 165: 468-478.
16. Kernberg OF, Yeomans FE, Clarkin JF, Levy KN. Transference focused psychotherapy: overview and update. Int J Psychoanal. 2008; 89: 601-620.
17. Gunderson JG. Clinical practice. Borderline personality disorder. N Engl J Med. 2011; 364: 2037-2042.
18. Bateman A, Fonagy P. Randomized controlled trial of outpatient mentalization-based treatment versus structured clinical management for borderline personality disorder. Am J Psychiatry. 2009; 166: 1355-1364.
19. Silverman MH, Schulz SC, Cullen KR. Using Functional Neuroimaging to Refine the Diagnostic Construct of Borderline Personality Disorder. Journal of Neuroimaging in Psychiatry & Neurology. 2016; 5: 27-45.
20. Goyer PF, Andreason PJ, Semple WE, Clayton AH, King AC, Compton-Toth BA, et al. Positron-emission tomography and personality disorders. Neuropsychopharmacology. 1994; 10: 21-28.
21. Schulz SC, Camchong J, Romine A, Schlesinger A, Kuskowski M, Pardo JV, et al. An exploratory study of the relationship of symptom domains and diagnostic severity to PET scan imaging in borderline personality disorder. Psychiatry Research: Neuroimaging. 2013; 214: 161-168.
22. Grant JE, Correia S, Brennan-Krohn T, Malloy P, Laidlaw DH, Schulz SC. Frontal white matter integrity in borderline personality disorder with self-injurious behavior. Journal of Neuropsychiatry and Clinical Neuroscience. 2007; 19: 383-390.
23. Stoffers J, Vollm BA, Rucker G, TImmer A, Huband N, LIeb K. Pharmacological interventions for borderline personality disorder. Cochrane Database Syst Rev. 2010; 16.
24. Simpson EB, Yen S, Costello E, Rosen K, Begin A, Pistoello J. Combined dialectical behavior therapy in the treatment of borderline personality disorder. J Clin Psychiatry. 2004; 65: 379-385.
25. Soler J, Pascaul JC, Camins J, Barrachina J, Puigdemont D, Alvarez E, et al. Double-blind, placebo-controlled study of dialectical behavior therapy plus olanzapine for borderline personality disorder. Am J Psychiatry. 2005; 162: 1221-1224.
26. Linehan MM, McDavid JD, Brown MZ, Sayrs JH, Gallop RJ. Olanzapine plus dialectical behavior therapy for women with high irritability who meet criteria for borderline personality disorder: a double-blind, placebo-controlled pilot study. J Clin Psychiatry. 2008; 69: 999-1005.
27. Tohen M. Pharmacologic treatments for borderline personality disorder. Am J Psych. 2014; 171: 1139-1141.
28. Cullen DR, La Riviere LL, Vizueta N, Thomas KM, Hunt RH, Miller MJ, et al. Brain activation in response to overt and covert fear and happy faces in women with borderline personality disorder. Brain Imaging and Behavior. 2016; 10: 319-331.
29. Kane JM, Robinson DG, Schooler NR, Mueser KT, Penn DL, Rosenheck RA, et al. Comprehensive Versus Usual Community Care for First-Episode Psychosis: 2-Year Outcomes from the NIMH RAISE Early Treatment Program. Am J Psych. 2016; 173: 362-372.

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