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Borderline and Narcissistic Disorders:
Practical Management

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Goals:

I. Review the DSM IV criteria for Borderline and Narcissistic Disorders...and some research and epidemiology data

II. Address old and new contextual realities in the treatment/management of these patients

III. Discuss twelve practical treatment/management strategies

DSM IV Criteria:

Cluster A... Personality Disorders: Paranoid, Schizoid, and Schizotypal...patients who appear odd or eccentric

Cluster B... Antisocial, Borderline, Histrionic, and Narcissistic...patients who appear dramatic, emotional, or erratic

Cluster C... Avoidant, Dependent, and Obsessive-Compulsive...patients who appear anxious or fearful

301.83 Borderline Personality Disorder

A pervasive pattern of instability of mood, interpersonal relationships, and self-image, and marked impulsivity 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.

Note: Do not include suicidal or self-mutilating behavior covered in criterion 5.

(2) a pattern of unstable and intense interpersonal relationships characterized by alternating between extreme 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). Note: Do not include suicidal or self-mutilating behavior covered in criterion 5.

(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 only 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

301.81 Narcissistic Personality Disorder

A pervasive pattern of grandiosity (in fantasy or behavior), lack of empathy, and hypersensitivity to the evaluation of others, beginning by early adulthood and present in a variety of contexts, as indicated by at least *five* of the following:

(1) has a grandiose sense of self-importance, (e.g., exaggerates achievements and talents, expects to be noticed as superior without commensurate achievements)

(2) is preoccupied with fantasies of unlimited success, power, brilliance, beauty or ideal love

(3) believes that he or she is special and unique and can only be understood by, or should associate with, other special or high-status people (or institutions)

(4) requires excessive admiration

(5) has a sense of entitlement, i.e., unreasonable expectations of especially favorable treatment or automatic compliance with his or her expectations

(6) is interpersonally exploitive, i.e., takes advantage of others to achieve his or her own ends

(7) lacks empathy: is unwilling to recognize or identify with the feelings and needs others

(8) is often envious of others or believes that others are envious of him or her

(9) shows arrogant, haughty behaviors or attitudes

Diagnostic criteria for 301.81 Borderline Personality Disorder reprinted with permission from the Diagnostic & Statistical Manual of Mental Disorders, Fourth Edition. Copyright 1994 American Psychiatric Assn.

Epidemiology and other Research Findings:

75% of Borderlines are women
11% of Outpatients are Borderlines
19% of Inpatients are Borderlines — Widiger and Francis, 1989

75% of Borderlines have a history of at least one self-injurious act
— Clarkin et al, 1983

9% of Borderlines commit suicide
35% of Borderlines with all 8 DSM III Criteria commit suicide
— Stone, 1989

75% of Borderlines have had childhood sexual abuse
— Herman et al, 1989

17% of Borderlines drop out of behavioral individual-group therapy during the first year
— Linehan et al, 1993

36% of Borderlines drop out of psychodynamic individual therapy during first six months
— Smith et al, 1995

66% of 550 Borderline patients followed up to 20 years after hospitalization were functioning well. — Stone, 1993

46% of Borderline patients reported having been a victim of violence since age 18. 50% of female patients and 26% of male patients report such violence.
— Zanarini, 1999

34.5% of a large sample of borderlines were in remission at 2 years, 49.4% at 4 years, 68.6% at 6 years. — Zanarini, 2003

40% of Borderline personality patients have abnormal diffuse slow activity on EEG.
— De la Fuente, 1998

Borderline personality disorder patients had significantly lower number of alpha2-adrenergic receptor binding sites than controls. Yehuda, 1994

Platelet MAO activity is significantly lower in male patients with Borderline personality disorder than controls with other psychiatric disorders.
Yehuda, 1989

Platelet 5-HT is positively correlated with Borderline Personality Disorder.
Verkes, 1998

Serum lipid levels are found to be low in patients with dissociative disorder with self-injurious behavior and borderline features
Agargun, 2004

Axis 1 co-morbidity is less frequent over time in patients with initially severe borderline personality disorder Zanarini, 2004

60% of Narcissistic patients will not qualify for the diagnosis after a 3 year followup which raises questions about the construct validity of this disorder.
Ronningstam et al, 1995

Contextual Realities that are affecting the treatment of Borderline and Narcissistic Personality Disorder

1. Symptom focused and brief therapies are being forced by Managed Care.

This has created much ferment: some argue that patients deprived of intensive psychodynamic therapy can not get better; others argue that symptom focus in the context of active therapy offers more hope for these patients.

A refreshing answer to this ferment is Marsha Linehan PhD's Dialectical Behavior Therapy…a group and individual program that is psychoeducational with four goals: a. Mindfulness b. Interpersonal effectiveness c. Emotional regulation d. Distress tolerance. Training offered

only to pairs or groups; Therapy is manual driven; Results from well-designed research protocol: better adherence to therapy, fewer hospital days, fewer self-injurious acts, better quality of relationships…vs. treatment as usual in the community. There is concern that patients don't feel better after a year of this treatment. Linehan, 1993.

A group at Cornell led by Clarkin and Kernberg have developed a transference-focused psychodynamic psychotherapy that research is demonstrating is effective. Clarkin, 2001 and Clarkin, 2004.

2. Fewer Residency Training Programs are including intensive psychotherapy experiences, a trend which invites less insight into transference and countertransference factors whenever Borderline or Narcissistic patients are confronted.

3. Evidence is emerging that childhood sexual trauma may be an important determinant of pathology in many borderline patients. There is also emerging evidence of neuropsychiatric dysfunction. These observations may allow for a more empathic approach to these distressing patients.

Twelve Practical Strategies for the Management of Borderline and Narcissistic Patients:

Thesis: Psychodynamic insight allows us to understand these patients and to ally with them. However, behavioral strategies allow us to help them!! There is more therapeutic power in the relationships outside of therapy than in the patient's relationship with the therapist.

1. If you can't or don't like the patient, get consultation immediately or get out of the alliance. This advice applies not only to psychotherapy but also to pharmacotherapy.

2. Be frank and straightforward with these patients...don't try to posture. Entertain sharing with the patient anything you might be likely to unload with a colleague after a session with the patient. Ideally, use the patient as a supervisor.

3. Avoid getting into the position of being angry at the patient. If the patient is making you angry, you aren't setting limits appropriately or you may be stuck in a countertransference distortion. Suicidal risk increases if the therapist gets angry or rejecting.

4. Be a teacher with these patients. e.g. Tell the patient what Borderline or Narcissistic Personality Disorder means or explain how we think someone acquires such a disorder. The patient should understand what the strategies of the therapy are, what your role is in making the therapy work, and what the patient's responsibilities are.

c.f.: Marsha Linehan's Dialectic Behavior Therapy. ...A good book for patients and families: Kreisman, J.J. I Hate You- Don't Leave Me (1991) New York: Avon Books..

5. Find a person in the patient's life around which to focus therapeutic work. Risks that the patient can take in the relationship with this person will clarify problems and define solutions, e.g. the patient's mother. Asking the patient to invite this person in for a session may be quite catalytic for growth. Unfortunately, most of the literature on both Borderline and Narcissistic Disorders is focused on fostering a relationship with the therapist from which to gain insight. It can be argued that this traditional approach has been both inefficient and self-serving.

6. Homework for the patient between visits fosters hopefulness and reinforces the importance of life outside as the place where change will occur. Homework is usually designed to encourage risks that will lessen anxiety and loneliness.

7. If the patient begins to make phone calls between visits, carefully define the meaning of the calls and your strategy in response. Calls do not always mean patient regression. A call may suggest progress. Be sure to decide a strategy that will not make you angry...or guilty.

8. Suicidal ideation or action may represent many issues, including the patient reminding himself or herself that there is a way out of the suffering. In this case, suicidal ideation may allow the patient to keep going. Suicidal action usually suggests a major problem in the therapeutic alliance that must be evaluated by a consultant. Contracting around suicidal ideation or civil commitment may render a therapeutic alliance unhelpful.

9. The patient's wish to depend on or fuse with the therapist may represent progress or resistance but can be anxiety provoking for the therapist or disastrously enjoyable. Avoid letting the therapy gradually become a constant in the patient's life that stops promoting change. Managed care companies will fund this kind of chronicity only if hospitalization can be avoided or other more expensive healthcare can be offset.

10. Pharmacologic management can present unique challenges with these patients. Always watch for significant and treatable Axis I problems. (Soloff, 1998). Always consider the dynamic and behavioral meaning of prescribing...or not prescribing!! Beware of the pitfalls...and consider the advantages of "split" treatment, i.e. non-medical psychotherapist working with medicating psychiatrist. Polypharmacy may be necessary. Beware of paradoxical reaction to meds. Important research in this area: Cowdry and Gardner, 1988; Rinne, 2002; Salzman, 1995.

11. Be willing to take a break from therapy when no progress is being made. A reassessment after a 3 month respite, for example, may crystallize the therapeutic alliance and goals.

12. A series of briefer therapies with the same or a different therapist during times of pain or crisis may serve these patients better than one long-term alliance.

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