Project Air Strategy Publications on Personality Disorders


Clinical literature frequently report that mental health professionals experience interpersonal challenges and emotional distress in providing treatment for patients with Borderline Personality Disorder (BPD). This study aimed to empirically investigate the clinical experience of therapists (N=20) in treating BPD (N=40) compared to Major Depressive Disorder (MDD; N=40). Prominent concepts and themes in therapists’ verbal descriptions of therapeutic process were examined using content analysis software. The Psychotherapy Relationship Questionnaire (PRQ) indexed therapists’ perceptions of patient’s relational patterns. Results revealed that therapists expressed greater emotional distress and an increased need for supportive supervision in their clinical work with patients with BPD. Therapists perceived patients with BPD as presenting with higher hostile, narcissistic, compliant, anxious, and sexualized dimensions of interpersonal responses than MDD. Using structured research tools we were able to elaborate and validate the interpersonal challenges and clinical stress experienced by therapists working with patients with BPD. (Abstract)


Background: No known recent studies have investigated service provision for personality disorder in Australia, despite international studies suggesting provision of such services is sub-optimal. Aims: This study aimed to gain insight into psychotherapy provided for personality disorders, treatments considered optimal by clinicians, and opinions of clinicians on the current levels of care. Methods: The views of 60 experienced clinicians working with personality disorders were sampled. Results: Data showed significant gaps between current practices for the treatment of personality disorders provided by clinicians compared to their perceptions of optimal treatment practice. Conclusions: This study highlights the evidence-practice gap and the need for more training for clinicians in the treatment of personality disorders and service improvements to implement optimal care strategies.


People with personality disorders are frequent users of both inpatient and outpatient psychiatric services, representing a significantly large proportion of all mental health clients. Despite this, most services find it a challenge to offer the most appropriate and effective treatment models for people with personality disorders. This paper is a report of a study of clinician opinions about how organizations can improve the delivery of services to people with personality disorders. Data was collected from experienced clinicians attending a personality disorders clinical and scientific meeting who were asked to work together in groups and present solutions for how organizations can improve the services provided to people with personality disorders. Qualitative data was collected and thematically and semantically analyzed using Nvivo and Leximancer. The Nvivo analysis revealed five main areas in which clinicians believe organizations can improve services for people with personality disorders. These focused on: (i) more training and education for health professionals and carers; (ii) better support through supervision and leadership; (iii) adoption of a more consistent evidence-based approach to client management and treatment; (iv) clearer guidelines and protocols; and (v) changed attitudes about personality disorder to decrease stigma. The Leximancer analysis of responses indicated the identified themes were not distinct; rather they were interconnected and related to one another, semantically. In summary, clinicians across a large and diverse geographical area developed a consensus that mainstream management of personality disorder is largely poor and inadequate. The findings lend support to an integrative and collaborative whole-service approach that enhances evidence-based practice in the community.

Objective: A small subgroup of patients is primarily responsible for the large number of aggressive and violent incidents in psychiatric inpatient units. This study aims to identify the developmental, social and interpersonal histories of repeatedly aggressive patients in order to better understand their treatment needs. Methods: A total of 1269 consecutive inpatients were studied over 18 months, identifying 64 who were repeatedly aggressive; 128 non-aggressive patients were randomly matched to the aggressive patients by age, sex and diagnosis. Developmental, social, interpersonal and familial histories were obtained from a chart review. Results: Repeatedly aggressive patients were significantly more likely to have had a history of aggression, physical and sexual abuse, and experienced interpersonal problems and parental divorce. Conclusions: Aggressive patients do not just need short-term skills training, but interventions that target interpersonal and personality disorder deficits associated with their developmental histories.


Clinicians recognize expressive language disturbances in borderline personality disorder (BPD) as a feature attenuating psychiatric history-taking. Neuroimaging studies demonstrate activation of key differentiating neural networks characterizing a traumatic memory system in BPD patients. Yet there are few BPD studies evaluating expressive language disturbances in response to emotionally salient, clinically relevant stimuli and no controlled studies. The aim was to examine expressive language disturbances in response to a clinically relevant emotional stimulus, the Adult Attachment Interview (AAI). Twenty BPD participants and 20 age-, sex-, and education-matched controls were administered the AAI. Verbatim transcripts were analyzed by four computerized measures designed to evaluate various linguistic components of speech (i.e., overall expressive language impairment, lexical complexity, syntactic complexity, and semantic complexity). BPD participants evidenced significantly greater levels of overall expressive language impairment and reduced syntactic and lexical complexity, but not semantic complexity scores. Detailed linguistic profiles demonstrated specific deficits linked to BPD.


Borderline personality disorder (BPD) is a disorder with known expressive language impairments that may be activated in treatment through interpersonal cues to the trauma memory system of these patients. However, there are few BPD studies investigating this phenomenon empirically. Our previous research is the first known investigation revealing expressive language deficits using clinically relevant trauma-salient stimuli; the current study extends this to compare specific expressive language deficits on a neutral and emotive stimulus and relationships with trauma history. BPD and matched control (N = 24) verbalizations were analysed by computerized measures of language impairment and pause profiles. BPD subjects evidenced greater overall language impairment and reduced syntactic complexity, but not semantic complexity compared with controls. No such differences were found between the two groups on the neutral condition. BPD subjects utilized significantly higher proportions of pauses for both the emotive and neutral condition. BPD subjects used significantly greater proportions of pauses when generating adjectives related to early relationship with mother, not father. Presence of physical abuse history and PTSD related to some expressive language deficits. These results support neuroimaging findings demonstrating reduced activation of the pre-frontal cortex or anterior cingulate, alongside increased bilateral activation of the amygdala, during exposure to trauma-salient stimuli.

(From the chapter) Pathological narcissism has long exerted an important hold on the imagination. Mythological, biblical, and other religious writings and doctrines have included sanctions against vanity and warnings about choosing self-love over the love of others and society. These dangers, long discussed in stories, paintings, and plays, have found a modern form in the presentation of a particular kind of personality style, narcissistic personality disorder, in psychology and psychiatry. The purpose of this overview is to demonstrate how contemporary views on pathological narcissism and its treatment can be enhanced through understanding the history of the concept. Understanding the historical roots of narcissism brings more clearly to light the contemporary implications of narcissism and the current debates and advances in the field (Ronningstam, 2009). I begin with the original Greek myth and then discuss the psychological literature up until 1979, which marks the publication of the narcissistic personality inventory (Raskin & Hall, 1979), followed 1 year later by the inclusion of narcissism as a personality disorder (Diagnostic and Statistical Manual of Mental Disorders, 3rd ed.; DSM-III; American Psychiatric Association, 1980). Considerable clinical, experimental, and theoretical work on narcissism has been undertaken since then (Cain, Pincus & Ansell, 2008).

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Read Professor Brin Grenyer’s description of how solving relationship conflicts are so important in personality disorders treatment.

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This study tested if children and adolescents with high levels of borderline personality features (BPF) exhibit the same shame-prone self-concept previously found to characterize adults with borderline personality disorder (Rüschi et al., 2007). Self-concept was indexed using the Implicit Association Test, in a community sample of children/adolescents aged 10 to 14 years (48% female; M age = 12.04 years). Common domains of child and adolescent psychopathology and core components of BPF were assessed using self-reports on the Strengths and Difficulties Questionnaire and the Borderline Personality Features Scale for Children. The identity problems component of BPF was found to significantly predict implicit levels of shame-prone self-concept, but only among girls. This effect was independent of the key dimensions of child and adolescent psychopathology that overlap with BPF—including features hyperactivity/inattention, disruptive behavior problems, and anxiety/depression—none of which were associated with shame-prone self-concept at the bivariate level or otherwise. The current findings provide preliminary evidence that self-schemas related to shame are uniquely associated with a core component of BPF in middle childhood and early adolescence and suggest that this correlate may apply uniquely to female individuals. These findings point to the identity problems component of BPF as a priority for future clinical and developmental research into mechanisms associated with BPF across childhood and adolescence.

This study examined the underlying factor structure of the DSM-IV criteria to determine whether the diagnosis could be classified into subtypes. It also sought to enhance the clinical interpretation of any identified subtypes by examining their relation to comorbid axis I and II disorders. In 95 treatment-seeking adults (82 women, 13 men), attending a psychiatric outpatient clinic principle components analysis yielded support for three subtypes: ‘affect dysregulation’, ‘rejection sensitivity’ and ‘mentalization failure’. Results of logistic regression analyses indicated that the affect dysregulation subtype was associated with the comorbid diagnosis of generalized anxiety and panic disorder and other cluster B and C personality disorders. The mentalization failure subtype was found to be predictive of posttraumatic stress disorder and other cluster B personality disorders. With further research, confirmation of these subtypes may inform diagnostic revisions and appropriate treatment regimes that are individually designed to target the patients’ core symptoms.


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Admission to personality disorder treatment programs is usually made on the basis of meeting diagnostic criteria, but what patients actually want from this treatment is seldom studied, or when to finish. Two studies were conducted into the early and late stages of an interpersonally based dynamic psychotherapy treatment program. At intake, 282 self-defined treatment goals of 100 patients seeking treatment for Borderline Personality Disorder were content analysed into four core treatment themes: ‘emotion dysregulation’, ‘mentalisation failure’, ‘rejection sensitivity’ and ‘quality of life’ issues. The single most important patient-defined goal of treatment related to ‘emotion dysregulation’, which included such goals as “I want to overcome my depression”, with anxiety and anger issues also common (54% of patients). Almost one quarter described problems similar to ‘mentalisation failure’ as central, including identity confusion, dissociative and stress-related worries. Sixteen percent verbalised wishing to reduce ‘rejection sensitivity’ associated with unstable relationships, self-harm behaviours, and abandonment issues. Nine percent of patients indicated that improving their ‘quality of life’ was of most significance, which included increased involvement in the community and reengaging in the work force. Towards the end of treatment, patients were asked to re-assess their goals and also to consider termination. Although symptoms and the severity of problems had reduced, and goals had been addressed, considerable ambivalence and tension was evident in contemplating life without the current therapist. Studying the lifetime history of treatment revealed frequent episodic therapy events and adjunct treatments, suggesting that a current course of treatment and goals needs to be understood within the longer course of a psychotherapy career. These results are understood within the context of current evidence-based practice recommendations.

Psychodynamic change is understood to occur in part through the unique therapeutic relationship developed between therapist and patient, and the subtle cycles of their conversation from relaxed connection to intense experiencing. The Therapeutic Cycles Model (TCM) (Mergenthaler, 1996) and Heidelberg Structural Change Scale (HSCS) (OPD Task Force, 2008) were used to investigate therapist-patient dynamic processes across 16 sessions of psychotherapy. The TCM identified interventions of the therapist instigating change in emotion-abstraction patterns. Structural personality change was higher in TCM cycles, and differed according to emotion-abstraction patterns. The interventions of the therapist promoted dynamic structural change in the patient. The findings demonstrate for the first time the interconnection between specific types of therapist and patient dialogue that promote deep changes.


This study examined therapists' emotional and cognitive responses to patients with borderline personality disorder (BPD) versus patients with major depressive disorder (MDD). Therapists’ narratives (N = 80) were elicited using the Relationship Anecdotes Paradigm interview method and then scored according to the core conflictual relationship theme-Leipzig/Ulm method (CCRT-LU; Albani et al., 2002). The emotional valences of therapists’ responses were significantly more negative toward patients with BPD. Therapists differentially experienced patients with BPD as typically withdrawing and patients with MDD as attending within sessions. Therapists felt less satisfied in their therapeutic role with BPD despite a consistent wish to help patients. Findings support the utility of the CCRT-LU method in investigating therapist relational experiences and underscore the challenges for BPD treatment.


There remains controversy surrounding the nature of the relationship between borderline personality disorder and posttraumatic stress disorder, with strong arguments that it would be more accurate and less stigmatizing for the former to be considered a trauma spectrum disorder. This article reviews the major criticisms of the DSM-IV diagnosis of borderline personality disorder that have fueled this controversy, including the absence of an etiology for the disorder, which is widely believed to be associated with early traumatic experiences. Also reviewed are recent attempts to redefine the disorder as a trauma spectrum variant based on the apparent overlap in symptomatology, rates of diagnostic comorbidity, and the prevalence of early trauma in individuals with a borderline diagnosis. The conceptual and theoretical problems for these reformulations are discussed, with particular reference to discrepancies in theoretical orientation, confusion of risk with causation, and the different foci of interventions for borderline personality disorder and posttraumatic stress disorder.