Borderline personality disorder scale pdf

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Step	Goal	Example
Describe diagnosis in terms that make it clear to the patient that this is a treatable condition, that the treatment is medical, and that you are going to help them	Describe chronic (as opposed to acute) pain Describe BPD as a condition where useful traits have become a liability	"In this kind of pain, your tissue is not being injured even though it feels like as if it is." "You are attuned to feelings more so than others but these feelings are dictating your behavior." "You cannot change how you feel but you can change what you do."
Delineate treatment goals in a therapeutically optimistic way	A clear description of the behavioral goals ,such as function, quality of life, and longevity	"Let's discuss some of the talents that you have and how you might be able to use them when you get well."
Develop a behavior plan that emphasizes specific rewards associated with specific accomplishments.	Describe the doctor's role and responsibilities and the patient's role and responsibilities	"When you complete your opiate taper, your parents have agreed to provide you with a weekly expense allowance." "When you are angry with me, it will be okay with me, and these are some acceptable ways to deal with those feelings that allow us to get through them together."
Treat comorbidities	Obtain a comprehensive history and treat comorbid mood disorders, addictive behaviors, and complicating life problems.	"We need to treat your depression aggressively, as it is likely further destabilizing the situation."
Identify strengths and build on them. Reframe vulnerabilities as assets and describe ways to use them.	Describe the positive side of emotional sensitivity and responsiveness as well as the ability to focus on now, feelings, and rewards.	"Your ability to sense the feelings of others allows you to have a powerful helping effect for other people."
Set limits	Confront behavior that impedes progress (with a smile)	"Can't means won't. Need means want. Think means feel."
Reward desired behavior	Make a fuss and applaud success	"Even though you were feeling upset, you still came into your appointment today. I am so proud of you! You are doing an amazing job."

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Assessment of borderline personality disorder: considering a diagnostic strategy

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Background: Borderline personality disorder (BPD) represents a highly prevalent, severe and difficult-to-treat mental health problem.
Objective: This paper considers methods, instruments and strategies for assessing BPD as described within the frame of the DSM-IV classification.
Conclusions: Following the general diagnostic approach introduced by Van Praag in biological psychiatry, a two-tier diagnostic strategy for the descriptive diagnostic assessment of BPD is recommended. Axis one results in a DSM-IV Axis II categorical diagnosis, whereas axis two refers to a symptomatological, dimensional or functional approach, in which the psychological dysfunctions of the nosological syndrome are depicted. Moreover, in a clinical context a basic aim of the diagnostic evaluation is to obtain therapeutically valid information that leads to a constructive conceptual framework, to a case formulation in which therapeutic interventions are understood, selected and implemented. This framework should be based on a biopsychosocial theoretical model and its application in the clinical context involves feedback to the patient, in which the descriptive evaluation is integrated with etiological; and pathogenic elements using an idiographic approach. This therapeutically orientated diagnostic strategy is illustrated by the use of the ADP-IV (Assessment of DSM-IV personality disorders) questionnaire within a cognitive behavioral orientation.

Keywords: borderline, personality disorder, assessment, diagnosis, DSM-IV axis II, ADP-IV

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Introduction

The combination of high severity and morbidity, high prevalence and serious challenges in treatment makes BPD one of the major areas of scientific and clinical interest. However, the 'borderline' construct involves problems of definition: it describes several diagnostic concepts and has many different meanings, depending on the tradition or discipline from which it is viewed. Considering this, Zanarini and Frankenburg note six main historical conceptualizations: as a level of personality organization (1) as, respectively, a schizophrenia, affective, impulse control or trauma spectrum disorder, or as a discrete personality disorder that can be described clearly and diagnosed differentially from other syndromes and states. The latter approach rests on a definitial use of borderline criteria sets and is embodied in the work of Gunderson and in the DSM-IV Axis II classification (2). This 'eclectic–descriptive' interpretation is the most described, researched and clinically applied definition of BPD. Therefore, in the present contribution the term BPD refers to the DSM-IV definition, in which the essential feature is a pervasive pattern of instability of interpersonal relationships, self-image and affects and marked impulsivity.

Descriptive assessment of BPD: a two-tier approach

Several authors (e.g. 3), rightly criticize the categorical format of the DSM-IV personality disorders

ORIGINAL PAPER

The outcomes of home treatment for borderline personality disorder

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Aims and method There is currently no trial or other scientific evidence informing the efficacy of any crisis intervention for people with borderline personality disorder (BPD). We aimed to assess the patterns of service use by patients with BPD taken on for crisis resolution and home treatment between 2010 and 2013. Patients with a diagnosis of BPD were identified and demographic and clinical data were collected.

Results All patients were female, and a high proportion had recurrent presentations to crisis and home treatment services in Edinburgh. Many appeared to benefit from intensive home treatment, as measured by the Clinical Global Impression scale. A small number of patients (n = 5) were responsible for more than half of all referrals. Polypharmacy, or regular use of multiple medications, was common, with 62% of all patients receiving three or more regular medications.

Clinical implications Crisis and home treatment services can be beneficial to most people with BPD in crisis. The high rate of polypharmacy seen in this study is of concern.

Declaration of interests M.T. works in a home treatment/crisis team.

Borderline personality disorder (BPD) is a complex and severe mental disorder that manifests as a pervasive pattern of instability in interpersonal relationships and self-image, mood disturbance, impulsive behaviours and repeated self-injury, and dissociation or quasi-psychotic experiences.[1,2] It is also associated with substantial impairment of social, psychological and occupational functioning and quality of life.[2] People with BPD are particularly at risk of suicide, with completed suicide occurring in 8–10% of individuals with this disorder, a rate that is approximately 50 times higher than the general population.[1]

BPD is the most common personality disorder seen in clinical settings. It is present in 10% of out-patient mental health clinics, 15–20% of psychiatric in-patients, and 30–60% of clinical populations with a personality disorder. It occurs in an estimated 2% of the general population and has an estimated gender ratio of more than 3:1 for women/men.[1]

The extent of the emotional and behavioural problems experienced by people with BPD varies considerably. Some people with BPD are able to sustain some relationships and occupational activities. Others, with more severe BPD, experience very high levels of emotional distress. They have repeated crises, which can involve self-harm and impulsive aggression, and can have high rates of comorbidity, including addictions. Despite this, people with BPD can be difficult to engage in treatment and frequently present to health services in crisis.[2] Because of the nature and potential consequences of these crises, the identification and utilisation of effective crisis management interventions with this population is of considerable importance.[3]

The Department of Health in England and Wales has recommended crisis resolution and home treatment (CRHT) in its best practice and policy implementation guides since 2002,[3] and in 2007 described CRHT as a key step in implementing the National Service Framework, partly to ensure in-patient care was used only where necessary.[3] National Health Service (NHS) services in Scotland were not constrained by the National Service Framework and did not incorporate functionalised teams such as assertive outreach, early intervention and CRHT teams until 2008.

In this observational study, we evaluated the current patterns of service use in patients with BPD taken on by Edinburgh Intensive Home Treatment Team (IHTT), which is a CRHT that facilitates early discharge from hospital as well as providing intensive home-based care. It was established in 2008 and has been linked to a reduction in psychiatric admissions and positive feedback.[3–4]

Method

Data were collected during a retrospective examination of medical records of all patients who had primary ICD-10 diagnosis of BPD (code F60.3) taken on by Edinburgh Intensive Home Treatment Team (IHTT) between 2010 and 2013 (4 years). Using unique patient identifiers, each included e-case record was reviewed using *a priori* criteria. IHTT records the severity of the presenting mental disorder using the Clinical Global Impression Scale (CGI)[5] at admission and clinicians note the improvement or lack thereof in the presenting condition via the CGI-I score at

Psychological Medicine

Impulsivity in Borderline Personality Disorder

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Abstract:	Background: Impulsivity is a core feature of borderline personality disorder (BPD) and is most frequently measured using self-rating scales. There is a need to find objective, valid and reliable measures of impulsivity. This study aimed to examine performance of participants with BPD compared to healthy controls on delay and probabilistic discounting tasks and the stop-signal task, which are objective measures of choice and motor impulsivity respectively. Methods: 20 participants with BPD and 21 healthy control participants completed delay and probabilistic discounting tasks and the stop signal task (SST). They also completed the Barratt Impulsiveness Scale (BIS), a self-rating measure of impulsivity. Results: Participants with BPD showed significantly greater delay discounting than controls, manifest as a greater tendency to accept the immediately available lesser reward rather than waiting longer for a greater reward. Similarly they showed significantly greater discounting of rewards by the probability of payout, which correlated with past childhood trauma. Participants with BPD were found to choose the more certain and/or immediate rewards, irrespective of the value. On the SST the BPD and control groups did not differ significantly, demonstrating no difference in motor impulsivity. There was no significant difference between groups on self-reported impulsivity as measured by the BIS. Conclusions: Measures of impulsivity show that while motor impulsivity was not significantly different in participants with BPD compared to controls, choice or reward related impulsivity was significantly affected in those with BPD. This suggests that choice impulsivity but not motor impulsivity is a core feature of BPD.

Schizophrenia-spectrum disorder Not to be confused with Semantic pragmatic disorder, Schizoid personality disorder, Schizoaffective disorder, or Autism spectrum disorder. Medical conditionSchizotypal disorderSpecialtyPsychiatrySymptomsIdeas of reference, unusual beliefs, perceptual Illusions, odd thinking and speech, suspiciousness, inappropriate affect, strange behavior, lack of friends, paranoid social anxietyComplicationsSchizophrenia, Substance use disorder, Major Depressive DisorderUsual onset10-20 year oldDurationlifelongRisk factorsFamily historyDifferential diagnosisCluster A personality disorders, borderline personality disorder, avoidant personality disorder, autism spectrum disorder, social anxiety disorder, ADHD-PI (ADD)Frequencyestimated 3% of general population Personality disorders Cluster A (odd) Paranoid Schizoid Schizotypal Cluster B (dramatic) Antisocial Borderline Histrionic Narcissistic Cluster C (anxious) Avoidant Dependent Obsessive–compulsive Not otherwise specified Depressive Depressive Cyclothymic Others Passive–aggressive Masochistic Sadistic Psychopathy Haltlose Immature Post-traumatic organic vte Schizotypal personality disorder (STPD or SPD), also known as schizotypal disorder, is a mental and behavioural disorder.[1] DSM classification describes the disorder specifically as a personality disorder characterized by thought disorder, paranoia, a characteristic form of social anxiety, derealization, transient psychosis, and unconventional beliefs. People with this disorder feel pronounced discomfort in forming and maintaining social connections with other people, primarily due to the belief that other people harbour negative thoughts and views about them.[2] Peculiar speech mannerisms and socially unexpected modes of dress are also characteristic. Schizotypal people may react oddly in conversations, not respond, or talk to themselves.[2] They frequently interpret situations as being strange or having unusual meaning for them; paranormal and superstitious beliefs are common. Schizotypal people usually disagree with the suggestion their thoughts and behaviour are a 'disorder', and seek medical attention for depression or anxiety instead.[3] Schizotypal personality disorder occurs in approximately 3% of the general population and is more commonly diagnosed in males.[4] The term "schizotype" was first coined by Sandor Rado in 1956 as an abbreviation of "schizophrenic phenotype".[5] STPD is classified as a cluster A personality disorder, also known as the "odd or eccentric" cluster. Causes Genetic Schizotypal personality disorder is widely understood to be a "schizophrenia spectrum" disorder. Rates of schizotypal personality disorder are much higher in relatives of individuals with schizophrenia than in the relatives of people with other mental illnesses or in people without mental illness. Technically speaking, schizotypal personality disorder may also be considered an "extended phenotype" that helps geneticists track the familial or genetic transmission of the genes that are implicated in schizophrenia pathogenesis.[6] But there is also a genetic connection of STPD to mood disorders and depression in particular.[7] Prediction of schizophrenia based on schizotypal traits has a higher accuracy for individuals with high genetic risk for STPD.[8] Social and environmental Unique environmental factors, which differ from shared sibling experiences, have been found to play a role in the development of STPD and its dimensions.[9] There is now evidence to suggest that parenting styles, early separation, trauma/maltreatment history (especially early childhood neglect) can lead to the development of schizotypal traits.[10][11] Neglect or abuse, trauma, or family dysfunction during childhood may increase the risk of developing schizotypal personality disorder. There is also evidence indicating insults in the prenatal environment could have an effect on development of STPD.[12] Over time, children learn to interpret social cues and respond appropriately but for unknown reasons this process does not work well for people with this disorder.[13] Schizotypal personality disorders are characterized by a common attentional impairment in various degrees that could serve as a marker of biological susceptibility to STPD.[14] The reason is that an individual who has difficulties taking in information may find it difficult in complicated social situations where interpersonal cues and attentive communications are essential for quality interaction. This might eventually cause the individual to withdraw from most social interactions, thus leading to asociality.[14] Diagnosis Screening There are various methods of screening for schizotypal personality. The Schizotypal Personality Questionnaire (SPQ) measures nine traits of STPD using a self-report assessment. The nine traits referenced are Ideas of Reference, Excessive Social Anxiety, Odd Beliefs or Magical Thinking, Unusual Perceptual Experiences, Odd or Eccentric Behavior, No Close Friends, Odd Speech, Constricted Affect, and Suspiciousness. A study found that of the participants who scored in the top 10th percentile of all the SPQ scores, 55% were clinically diagnosed with STPD.[15] A method that measures the risk for developing psychosis through self-reports is the Wisconsin Schizotypy Scale (WSS).[16] The WSS divides schizotypal personality traits into 4 scales for Perceptual Aberration, Magical Ideation, Revised Social Anhedonia, and Physical Anhedonia.[17][18][3] A comparison of the SPQ and the WSS suggests that these measures should be cautiously used for screening purposes of STPD.[18] STPD as a Personality Disorder DSM-5 In the American Psychiatric Association's DSM-5, schizotypal personality disorder is defined as a "pervasive pattern of social and interpersonal deficits marked by acute discomfort with, and reduced capacity for, close relationships as well as by cognitive or perceptual distortions and eccentricities of behavior, beginning by early adulthood and present in a variety of contexts."[3] At least five of the following symptoms must be present: ideas of reference strange beliefs or magical thinking that influences behavior and is inconsistent with subcultural norms (e.g., superstitiousness, belief in clairvoyance, telepathy, or “sixth sense”, bizarre fantasies or preoccupations) abnormal perceptual experiences, including bodily illusions strange thinking and speech (e.g., vague, circumstantial, metaphorical, overelaborate, or stereotyped) suspiciousness or paranoid ideation inappropriate or constricted affect strange behavior or appearance lack of close friends excessive social anxiety that does not diminish with familiarity and tends to be associated with paranoid fears rather than negative judgments about self These symptoms must not occur only during the course of a disorder with similar symptoms (such as schizophrenia or autism spectrum disorder).[3] STPD as a Clinical Disorder ICD-10 The World Health Organization's ICD-10 uses the name schizotypal disorder (F21). It is classified as a clinical disorder associated with schizophrenia, rather than a personality disorder as in DSM-5.[19] The ICD definition is: A disorder characterized by eccentric behavior and anomalies of thinking and affect which resemble those seen in schizophrenia, though no definite and characteristic schizophrenic anomalies have occurred at any stage. There is no dominant or typical disturbance, but any of the following may be present: Inappropriate or constricted affect (the individual appears cold and aloof); Behavior or appearance that is odd, eccentric or peculiar; Poor rapport with others and a tendency to withdraw socially; Odd beliefs or magical thinking, influencing behavior and inconsistent with subcultural norms; Suspiciousness or paranoid ideas; Obsessive ruminations without inner resistance; Unusual perceptual experiences including somatosensory (bodily) or other illusions, depersonalization or derealization; Vague, circumstantial, metaphorical, over-elaborate or stereotyped thinking, manifested by odd speech or in other ways, without gross incoherence; Occasional transient quasi-psychotic episodes with intense illusions, auditory or other hallucinations and delusion-like ideas, usually occurring without external provocation. The disorder runs a chronic course with fluctuations of intensity. Occasionally it evolves into overt schizophrenia. There is no definite onset and its evolution and course are usually those of a personality disorder. It is more common in individuals related to people with schizophrenia and is believed to be part of the genetic "spectrum" of schizophrenia. Diagnostic guidelines This diagnostic rubric is not recommended for general use because it is not clearly demarcated either from simple schizophrenia or from schizoid or paranoid personality disorders, or possibly autism spectrum disorders as currently diagnosed. If the term is used, three or four of the typical features listed above should have been present, continuously or episodically, for at least two years. The individual must never have met criteria for schizophrenia itself. A history of schizophrenia in a first-degree relative gives additional weight to the diagnosis but is not a prerequisite. Subtypes Theodore Millon proposes two subtypes of schizotypal personality.[5][20] Any individual with schizotypal personality disorder may exhibit either one of the following somewhat different subtypes (Note that Millon believes it is rare for a personality with one pure variant, but rather a mixture of one major variant with one or more secondary variants): Subtype Description Personality traits Insipid schizotypal A structural exaggeration of the passive-detached pattern. It includes schizoid, depressive and dependent features. Sense of strangeness and nonbeing; overtly drab, sluggish, inexpressive; internally bland, barren, indifferent, and insensitive; obscured, vague, and tangential thoughts. Timorous schizotypal A structural exaggeration of the active-detached pattern. It includes avoidant and negativistic features. Warily apprehensive, watchful, suspicious, guarded, shrinking, deadens excess sensitivity; alienated from self and others; intentionally blocks, reverses, or disqualifies own thoughts. Treatment Medication STPD is rarely seen as the primary reason for treatment in a clinical setting, but it often occurs as a comorbid finding with other mental disorders. When patients with STPD are prescribed pharmaceuticals, they are usually prescribed neuroleptics of the sort used to treat schizophrenia; however, the use of neuroleptic drugs in the schizotypal population is in great doubt.[21] While people with schizotypal personality disorder and other attenuated psychotic-spectrum disorders may have a good outcome with neuroleptics in the short term, long-term followup suggests significant impairment in daily functioning compared to schizotypal and even schizophrenic people without neuroleptic drug exposure.[22] Antidepressants are also sometimes prescribed, whether for STPD proper or for comorbid anxiety and depression.[21] Therapy According to Theodore Millon, schizotypal personality disorder is one of the easiest personality disorders to identify but one of the most difficult to treat with psychotherapy.[5] Persons with STPD usually consider themselves to be simply eccentric or nonconformist; the degree to which they consider their social nonconformity a problem differs from the degree to which it is considered a problem in psychiatry. It is difficult to gain rapport with people with STPD due to the fact that increasing familiarity and intimacy usually increase their level of anxiety and discomfort.[23] Group therapy is recommended for persons with STPD only if the group is well structured and supportive. Otherwise, it could lead to loose and tangential ideation.[clarification needed][21] Support is especially important for schizotypal patients with predominant paranoid symptoms, because they will have a lot of difficulties even in highly structured groups.[24] Comorbidity Schizotypal personality disorder frequently co-occurs with major depressive disorder, dysthymia and social phobia.[25] Furthermore, sometimes schizotypal personality disorder can co-occur with obsessive–compulsive disorder, and its presence appears to affect treatment outcome adversely.[26] Some people with a clinical diagnosis of OCD have been found to also possess many schizotypal personality traits resulting in what can be called ‘schizotypal OCD’.[27] Without proper treatment, STPD tendencies, such as magical thinking and paranoid ideation, could worsen the symptoms of OCD in an individual.[28] There may also be an association with bipolar disorder.[29] People with Gilles de la Tourette syndrome (GTS) can commonly possess some schizotypal traits.[30] In terms of comorbidity with other personality disorders, schizotypal personality disorder has high comorbidity with schizoid and paranoid personality disorder, the other two 'Cluster A' conditions.[31] It also has significant comorbidity with borderline personality disorder and narcissistic personality disorder.[29] Some schizotypal people go on to develop schizophrenia,[32] but most of them do not.[33] There are dozens of studies showing that individuals with schizotypal personality disorder score similar to individuals with schizophrenia on a very wide range of neuropsychological tests. Cognitive deficits in patients with schizotypal personality disorder are very similar to, but quantitatively milder than, those for patients with schizophrenia.[34] A 2004 study, however, reported neurological evidence that did "not entirely support the model that SPD is simply an attenuated form of schizophrenia".[35] Epidemiology Reported prevalence of STPD in community studies ranges from 0.6% in a Norwegian sample, to 4.6% in an American sample.[3] A large American study found a lifetime prevalence of 3.9%, with somewhat higher rates among men (4.2%) than women (3.7%).[4] It may be uncommon in clinical populations, with reported rates of up to 1.9%.[3] Together with other cluster A personality disorders, it is also very common among homeless people who show up at drop-in centres, according to a 2008 New York study. The study did not address homeless people who do not show up at drop-in centres.[36] Cannabis users, whether that be a lifetime use, abuse or dependence, have been found to have an increased likelihood of possessing schizotypal personality disorder or traits consistent with STPD.[37] Another epidemiological study on suicidal behavior in STPD found that, even when accounted for sociodemographic factors, people with STPD were 1.51 times more likely to attempt suicide. The same study found that people with childhood adversities, specifically abuse by a parent or caretaker, have a strongly significant association with lifetime STPD.[38] See also Psychology portal Boundaries of the mind DSM-5 codes (personality disorders) Paranoid personality disorder Schizoid personality disorder Schizotypy References ^ Sartorius N, Henderson A, Strotzka H, Lipowski Z, Yu-cun S, You-xin X, et al. 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