Capio Hospital General de Catalunya

Limit

IV Simposio sobre Trastorno Límite de la Personalidad

Tratamiento a largo plazo. ¿Podemos ser optimistas?

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Borderline personality disorder

Klaus Lieb, Mary C Zanarini, Christian Schmahl, Marsha M Linehan, Martin Bohus

Lancet 2004; 364: 453–61

Panel: DSM-IV criteria for borderline personality disorder*

Affective criteria

- Inappropriate intense anger or difficulty controlling anger—eg, frequent displays of temper, constant anger, recurrent physical fights
- Chronic feelings of emptiness
- Affective instability due to a marked reactivity of mood—eg, intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days

Cognitive criteria

- Transient stress-related paranoid ideation or severe dissociative symptoms
- Identity disturbance: striking and persistent unstable self-image or sense of self

Behavioural criteria (forms of impulsivity)

- Recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour
- Impulsivity in at least two areas that are potentially self-damaging that do not include suicidal or self-mutilating behaviour

Interpersonal criteria

- Frantic efforts to avoid real or imagined abandonment that do not include suicidal or self-mutilating behaviour
- A pattern of unstable and intense interpersonal relationships characterised by alternating between extremes of idealisation and devaluation

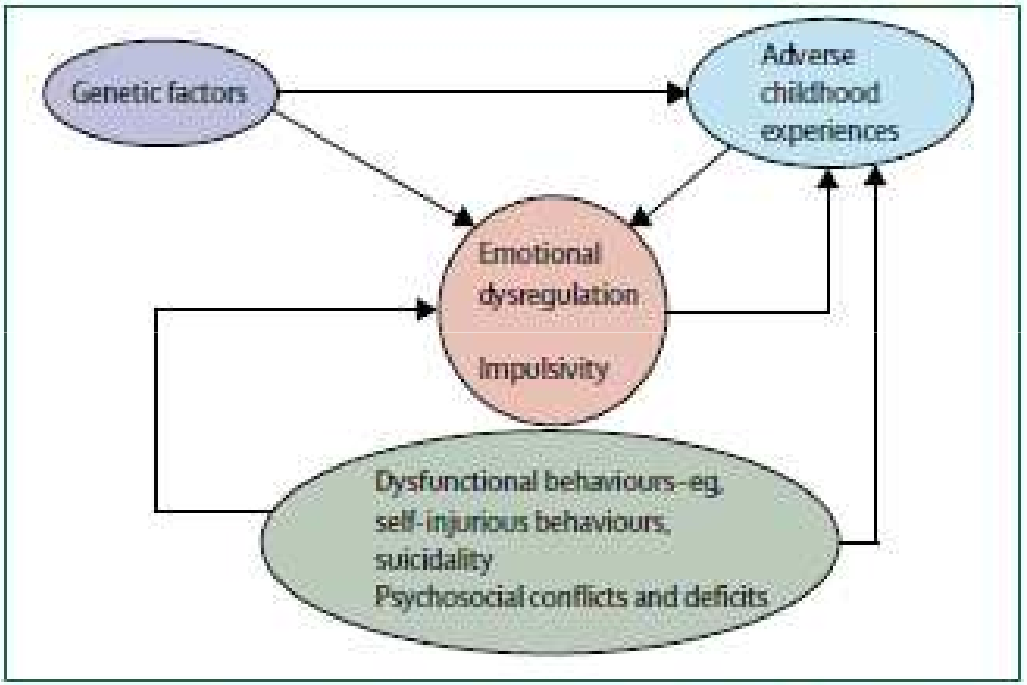
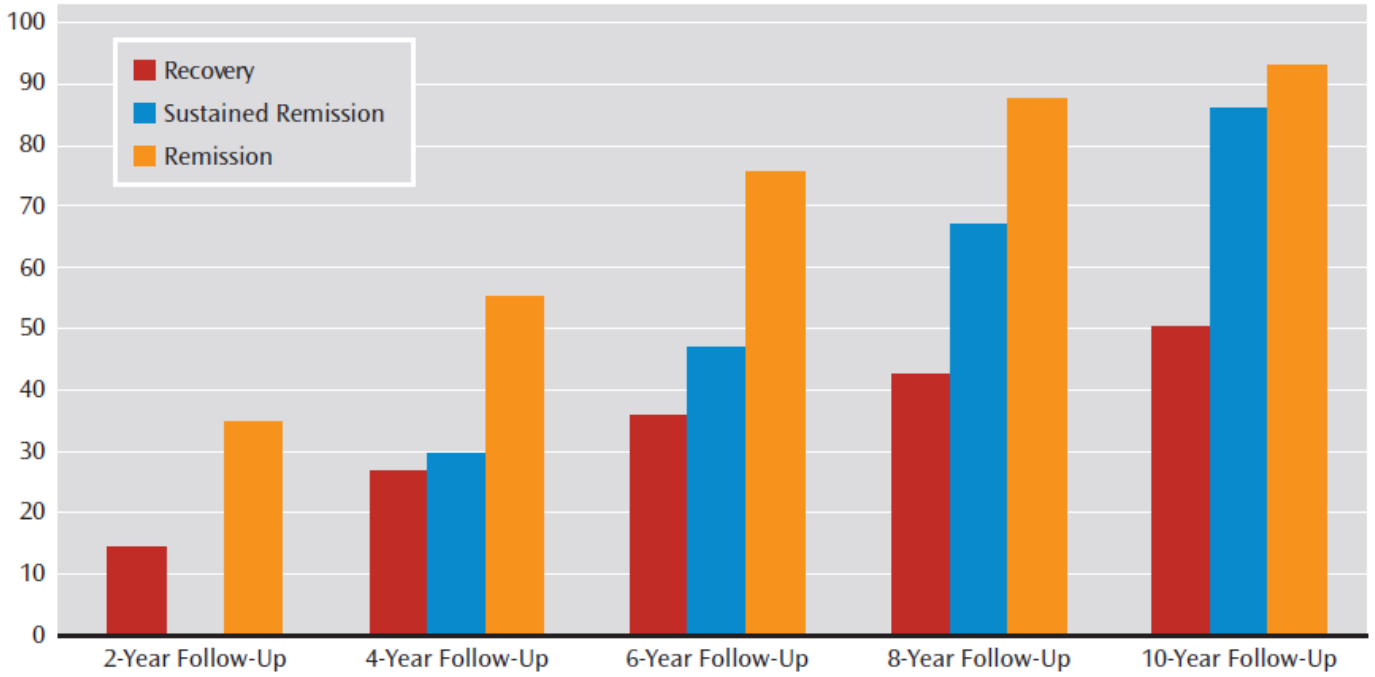


Figure: Neurobehavioural model of borderline personality disorder

Curso longitudinal del TLP

Tiempo para la recuperación parcial, total y recaídas



[a] Remission is defined as no longer meeting DSM-III-R and Revised Diagnostic Interview for Borderlines criteria for borderline personality disorder for at least 2 years, and sustained remission as no longer meeting criteria for at least 4 years. Recovery is defined as having remission of symptoms and having good social and vocational functioning during the previous 2 years.

Zanarini et al., Am J Psych 2010

Curso longitudinal de la psicopatología limite: seis años de seguimiento

Remisión: 34,5% a 2 años, 49,4% a 4 años, 68,6% a los
Recurrencias: 6% a los 4años, 4,6% a los 6años (5,9% en total)

Reducción de síntomas de manera diferenciada a lo largo del tiempo:

1. **Manifestaciones agudas** (remisión a los 2 años): automutilación, intentos de suicidio, pensamientos casi psicotico, las regresiones del tratamiento y los problemas de controtransferencia,

2. **Aspecto temperamental o resistente** (persisten a los 6 años): sentimientos crónicos de vacio o cólera, desconfianza, dificultad para tolerar la soledad y preocupaciones de sufrir de abandono

Zanarini et al., Am J Psych 2003

Curso longitudinal de la psicopatología limite: seis años de seguimiento

seguimiento

2 años

6 años

Síntomas impulsivos

(Abuso de substancias, desviación sexual, automutilación, intentos manipuladores de suicidio y otras tipologías impulsivas). Estos síntomas fueron los que se resolvieron con mayor frecuencia y antes.

6 años: intentos de automutilación y de suicidio (25%) , el abuso de substancias (25%), la desviación sexual (12%).

Por lo contrario, atracones de comida, arrebatos verbales y malgastar dinero: 65%

Síntomas cognitivos e interpersonales

Pensamientos extraños o experiencias perceptivas inusuales, paranoia no delirante, pensamiento casi psicótico , exigencia o autoritarismo, regresión del tratamiento, problemas de controtransferencia.

6 años: Los pensamientos extraños o experiencias perceptivas inusuales y la paranoia no delirante eran muy frecuentes (85%) y después de 6años la mitad de los pacientes seguía describiendo estos síntomas.

Entre las manifestaciones interpersonales, las regresiones al tratamiento y los problemas de controtransferencia (10%.)

60% de los pacientes presentaban intolerancia a la soledad, preocupaciones de abandono, contradependencia y dependencia/masoquismo

Síntomas afectivos

(Depresión cronica o grave, sentimientos cronicos de impotencia, desesperancia, inutilidad o culpa; enfado crónico o actos airados frcuentes, ansiedad crónica, soledad, aburrrimiento, o vacio crónicos):

Se resolvieron con menor frecuencia. 61%-79% (6 años)

Zanarini et al., Am J Psych 2003

Curso longitudinal de la psicopatología limite: 10 años de seguimiento

Tiempo medio de remisión de los 24 sintomas del TLP en 290 pacientes.

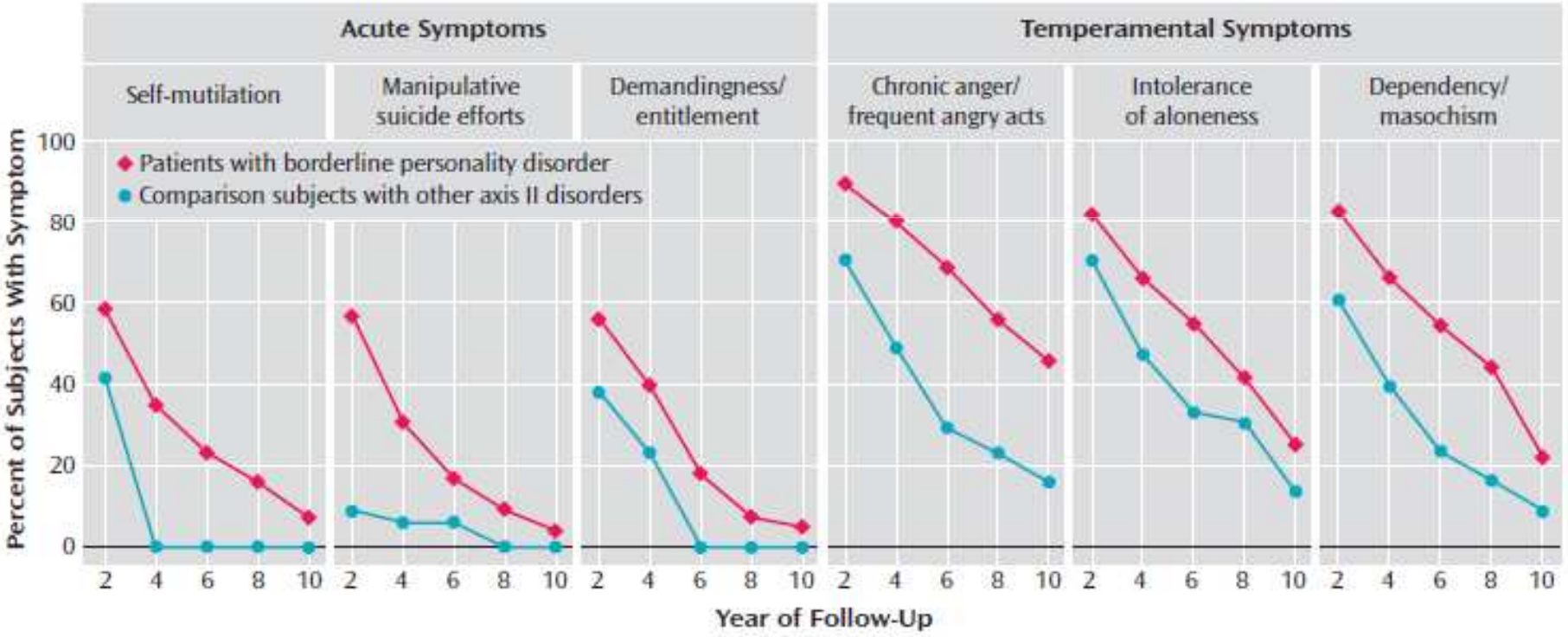
Symptoms and Median Time to Remission
0–2 years
Quasi-psychotic thought
Sexual deviance
Treatment regressions
Countertransference problems/"special" treatment relationships
2–4 years
Substance abuse/dependence
Self-mutilation
Manipulative suicide efforts
Demandingness/entitlement
Serious identity disturbance
4–6 years
Odd thinking/unusual perceptual experiences
Nondelusional paranoia
Abandonment/engulfment/annihilation concerns
Stormy relationships
Devaluation/manipulation/sadism
Affective instability
6–8 years
Chronic/major depression
Chronic feelings of helplessness/hopelessness/worthlessness/guilt
Chronic anxiety
General impulsivity
Intolerance of aloneness
Counterdependency/serious conflict over help/care
Dependency/masochism
8–10 years
Chronic anger/frequent angry acts
Chronic loneliness/emptiness

Zanarini et al., Am J Psych 2007

Limit

Curso longitudinal de la psicopatología limite:
10 años de seguimiento

FIGURE 1. Percentage of Patients With Borderline Personality Disorder and Comparison Patients With Other Axis II Disorders Who Retained Three Acute and Three Temperamental Borderline Symptoms From Baseline Through Five 2-Year Follow-Up Periods



Zanarini et al., Am J Psych 2007

Curso longitudinal de la psicopatología limite: 10 años de seguimiento

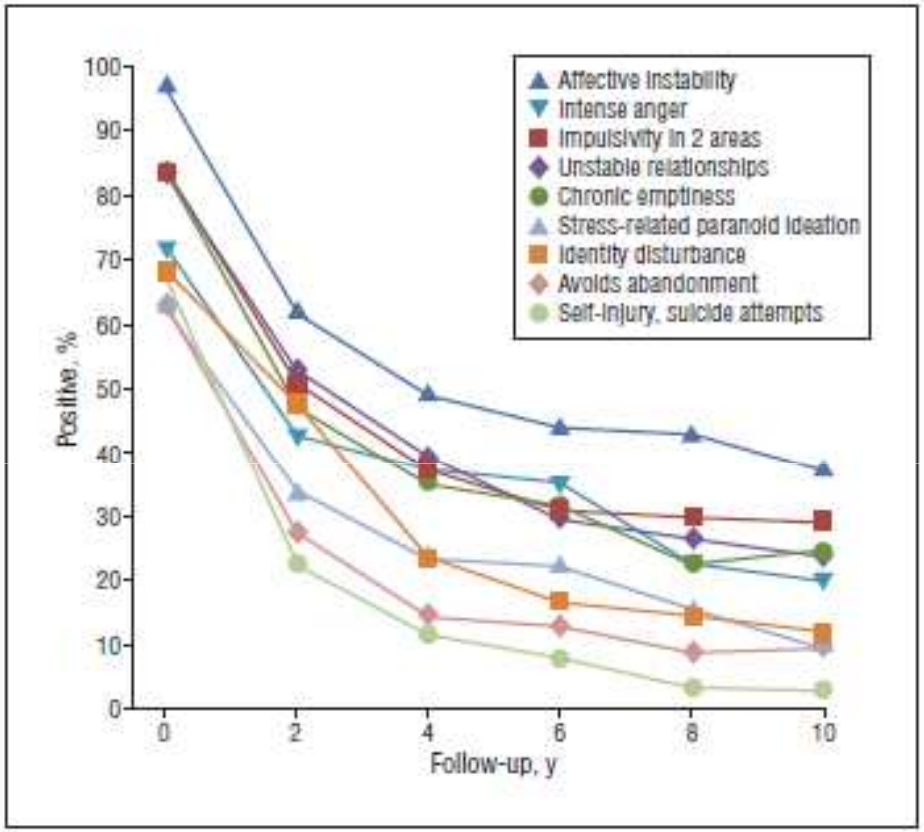


Figure 2. Prevalence of borderline personality disorder criteria. Positive indicates the cases with a score of 2 (definitely present and clinically significant) for each of the 9 borderline personality disorder criteria on the Diagnostic Interview for *DSM-IV* Personality Disorders, assessed for the 2 years prior to the follow-up point.

Gunderson et al., Arch Gen Psych 2011

Curso longitudinal de la psicopatología limite: 10 años de seguimiento

Remisión funcional (GAF > 70 durante 2 meses)

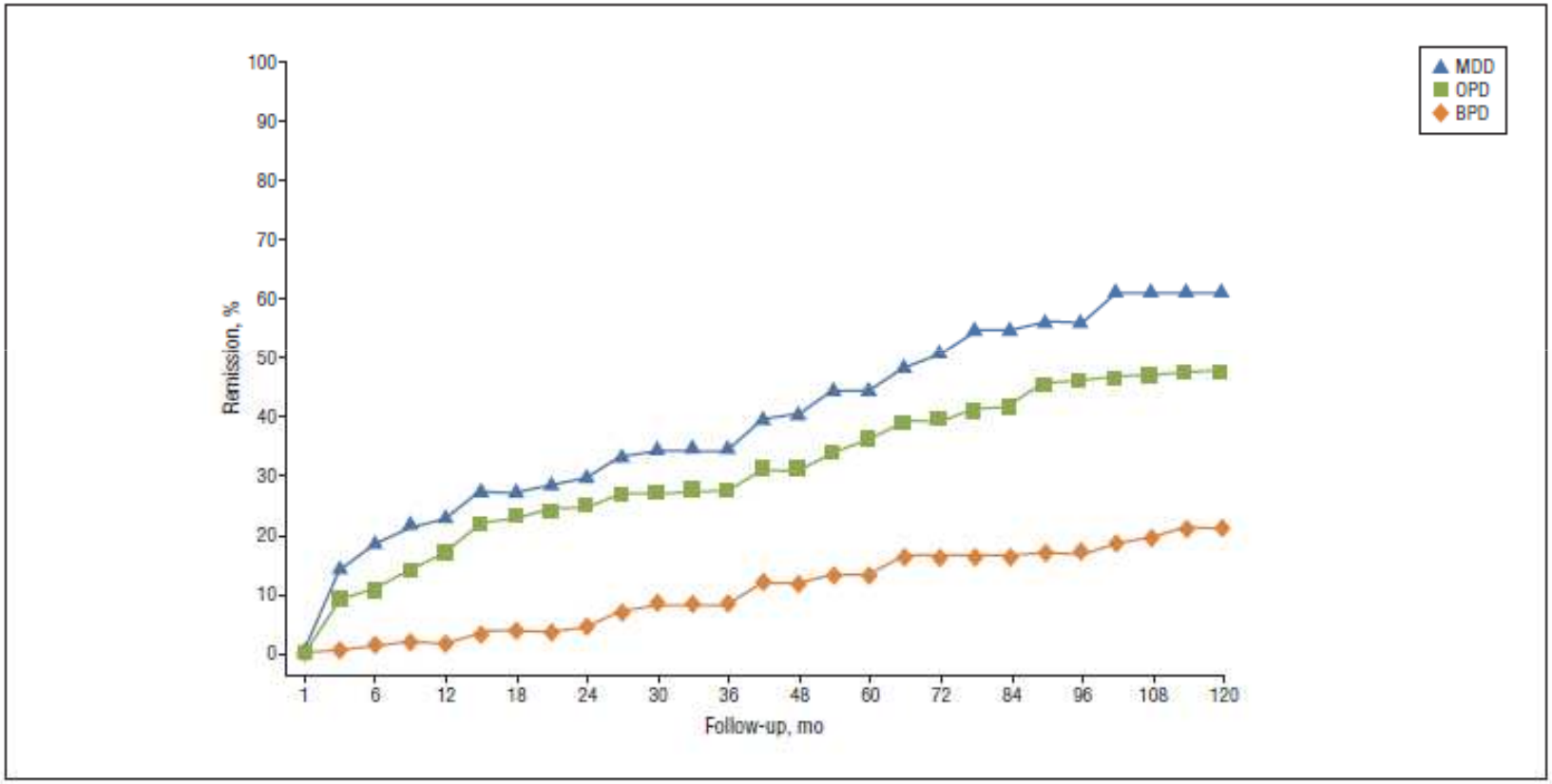


Figure 4. Functional remission, defined as a Global Assessment of Functioning score greater than 70 sustained for 2 months. Analyses were conducted using lifetest survival estimates. MDD indicates major depressive disorder; OPD, other personality disorders; and BPD, borderline personality disorder.

Gunderson et al., Arch Gen Psych 2011

Comorbididad y curso

Table 2. Comorbid axis II disorders experienced by remitted and non-remitted borderline patients followed prospectively for 6 years

	Remitted BPD patients (%/N)				Non-remitted BPD patients (%/N)				Model		z-score		P-level		
	BL ($N = 202$)	2-year FU ($N = 202$)	4-year FU ($N = 201$)	6-year FU ($N = 200$)	BL ($N = 88$)	2-year FU ($N = 73$)	4-year FU ($N = 68$)	6-year FU ($N = 64$)	χ^2-value	P-level	Dx	Time	Dx	Time	Significant covariates
Odd cluster	23.8 (48)	8.9 (18)	7.0 (14)	2.0 (4)	30.7 (27)	27.4 (20)	10.3 (7)	7.8 (5)	75.4	<0.0001	−2.793	−7.930	0.005	<0.001	Male, lower SES
Paranoid	23.3 (47)	6.9 (14)	5.5 (11)	1.5 (3)	30.7 (27)	26.0 (19)	8.8 (6)	7.8 (5)	73.9	<0.0001	−2.850	−7.984	0.004	<0.001	Lower SES
Schizoid	0.5 (1)	1.0 (2)	2.0 (4)	1.0 (2)	1.1 (1)	1.4 (1)	1.5 (1)	0.0 (0)	4.6	NS	0.181	0.539	NS	NS	Male
Schizotypal	2.0 (4)	1.5 (3)	0.5 (1)	0.0 (0)	3.4 (3)	0.0 (0)	0.0 (0)	1.6 (1)	5.3	NS	−0.782	−2.160	NS	0.031	-
Anxious cluster	62.4 (126)	43.6 (88)	35.3 (71)	20.0 (40)	85.2 (75)	69.9 (51)	76.5 (52)	71.9 (46)	139.1	<0.0001	−7.145	−9.287	<0.001	<0.001	More treatment
Avoidant	36.1 (73)	24.3 (49)	26.4 (53)	15.5 (31)	50.0 (44)	45.2 (33)	52.9 (36)	59.4 (38)	63.0	<0.0001	−4.366	−3.628	<0.001	<0.001	Lower GAF, more treatment
Dependent	41.6 (84)	30.7 (62)	21.4 (43)	7.5 (15)	56.7 (49)	48.0 (35)	48.5 (33)	45.3 (29)	100.6	<0.0001	−4.377	−8.555	<0.001	<0.001	More treatment
Obsessive compulsive	15.8 (32)	4.5 (9)	3.5 (7)	3.0 (6)	12.5 (11)	5.5 (4)	2.9 (2)	1.6 (1)	32.1	<0.0001	0.367	−5.665	NS	<0.001	-
Passive aggressive	18.8 (38)	9.4 (19)	7.0 (14)	2.5 (5)	27.3 (24)	17.8 (13)	19.1 (13)	7.8 (5)	61.3	<0.0001	−2.753	−6.340	0.006	<0.001	Male, lower SES
Self-defeating	21.8 (44)	10.4 (21)	6.5 (13)	1.0 (2)	34.1 (30)	30.1 (22)	27.9 (19)	26.6 (17)	69.4	<0.0001	−5.976	−6.429	<0.001	<0.001	-
Dramatic cluster (without BPD)	27.7 (56)	4.0 (8)	4.5 (9)	4.0 (8)	51.1 (45)	19.2 (14)	19.1 (13)	10.9 (7)	99.6	<0.0001	−5.153	−8.811	<0.001	<0.001	Male, lower SES
Antisocial	18.8 (38)	2.5 (5)	0.0 (0)	2.0 (4)	30.7 (27)	5.5 (4)	0.0 (0)	3.1 (2)	56.9	<0.0001	−1.568	−6.954	NS	<0.001	Male, lower SES, lower GAF
Histrionic	8.4 (17)	1.5 (3)	3.5 (7)	1.5 (3)	15.9 (14)	6.9 (5)	11.8 (8)	6.3 (4)	22.5	<0.0001	−3.324	−3.556	0.001	<0.001	-
Narcissistic	6.9 (14)	0.0 (0)	1.5 (3)	1.5 (3)	19.3 (17)	8.2 (6)	13.2 (9)	1.6 (1)	32.1	<0.0001	−4.202	−4.148	<0.001	<0.001	Male
Sadistic	1.0 (2)	0.0 (0)	0.0 (0)	0.0 (0)	6.8 (6)	1.4 (1)	1.5 (1)	0.0 (0)	19.2	0.0007	−2.151	−2.452	0.031	0.014	Younger, lower GAF

Values in parentheses are *n*-values

GAF, Global Assessment of Functioning; BPD, borderline personality disorder; FU, follow-up; BL, baseline; SES, socioeconomic status.

Zanarini et al., Acta Psych Scand 2004

Tratamiento a largo plazo: Psicoterapia

Table 2. Four Evidence-Based Treatments for Borderline Personality Disorder.*

Type of Therapy	Description
Dialectical behavior therapy	A behavioral therapy that includes both individual and group therapy, involving didactics and homework on mood monitoring and stress management; the best validated and easiest to learn of the psychotherapies, one that teaches the patient how to regulate feelings and behaviors, with the therapist acting as a coach with extensive availability
Mentalization-based therapy	A cognitive or psychodynamic therapy that includes both individual and group therapy, in which the therapist adopts a "not-knowing" stance while insisting that the patient examine and label his or her own experiences and those of others (i.e., mentalizing); emphasis on thinking before reacting (a process that may be central to all effective therapies)
Transference-focused psychotherapy	A twice-weekly individual psychotherapy developed from psychoanalysis that includes interpretation of motives or feelings unknown to the patient and retains a focus on the patient's misunderstanding of others, especially of the therapist (i.e., transference); the least supportive and hardest to learn of the therapies
General psychiatric management	A once-weekly psychodynamic therapy developed from the APA guidelines[3,4] and the basic BPD treatment textbook,[2] focusing on the patient's interpersonal relationships but also possibly including family interventions and pharmacologic therapy; the least theory-bound and easiest to learn of the therapies but least well evaluated

* APA denotes American Psychiatric Association, and BPD borderline personality disorder.

Gunderson., The New England Journal of Medicine 2008

Estudios Clínicos Aleatorizados Controlados

	Treatment	Comparison
Bateman and Fonagy[119]	Mentalisation-based treatment in a partial hospital setting	Treatment as usual
Bateman and Fonagy[118]	Mentalisation-based psychodynamic treatment	Structured clinical management
Blum et al[120]	Brief cognitive-behavioural therapy plus treatment as usual	Treatment as usual
Bohus et al[121]	Inpatient dialectical behaviour therapy	Treatment as usual
Clarkin et al[122]	Transference-focused therapy	Dialectical behaviour therapy as supportive therapy
Cottraux et al[123]	Cognitive-behavioural therapy	Client-centred therapy
Davidson et al[139]	Brief cognitive-behavioural therapy plus treatment as usual	Treatment as usual
Doering et al[132]	Transference-focused therapy	Community treatment by experienced therapists
Farrel et al[124]	Schema-focused therapy plus treatment as usual	Treatment as usual
Giesen-Bloo et al[125]	Schema-focused therapy	Transference-focused therapy
Gregory et al[126]	Dynamic deconstructive therapy	Treatment as usual
Harned et al[127]	Dialectical behaviour therapy	Community treatment by experts
Koons et al[134]	Dialectical behaviour therapy	Treatment as usual
Linehan et al[130]	Dialectical behaviour therapy	Treatment as usual
Linehan et al[112]	Dialectical behaviour therapy	Treatment as usual
Linehan et al[111]	Dialectical behaviour therapy	Comprehensive validation therapy plus a 12-step substance misuse programme
Linehan et al[128]	Dialectical behaviour therapy	Therapy by experts
McMain et al[129]	Dialectical behaviour therapy	Psychodynamically informed clinical management
Munroe-Blum et al[116]	Psychodynamic therapy	Interpersonal group therapy
Soler et al[135]	Dialectical behaviour therapy skills training	Standard group therapy
Tyrer et al[137]	Brief cognitive-behaviour therapy	Treatment as usual
Turner et al[115]	Dialectical behaviour therapy	Client-centred therapy
Verheul et al[131]	Dialectical behaviour therapy	Treatment as usual
Weinberg et al[133]	Brief cognitive-behavioural therapy plus treatment as usual	Treatment as usual

Table 2: **Randomised controlled trials of psychotherapy in patients with borderline personality disorder**

Leicshering et al., The Lancet 2011

Limit

Terapias psicodinamicas

1. MENTALIZATION-BASED TREATMENT. (Bateman and Fonagy ,1999)

Objetivo: aumentar la curiosidad y habilidad en la identificación de sentimientos y pensamientos y los de otras personas. (dificultades en el apego temprano). (Bateman y Fonagy Am J Psych 1999-2000-2003-2006

- 18 meses de seguimiento: reducción de actos de auto-agresión y suicida, días de hospitalizaciones, uso de medicamentos psicotrópicos, ansiedad y síntomas depresivos, y el funcionamiento psicosocial.
- 5-años de seguimiento: suicidio, sintomas TLP, uso de servicios, uso de medicación, GAF por encima de 60, y el estatus profesional.
- Sin embargo, el funcionamiento profesional es inferior al óptimo esperado

2. TRANSFERENCE-FOCUSED PSYCHOTHERAPY. (conceptualización de Kernberg)

Objetivo: reducir el comportamiento autodestructivo a través de la modificación de las representaciones del yo y otras personas (Clarkin Am J PSYC 2007; Doering et al, Br J Psych 2010)

- 1-3-años de seguimiento: (Clarkin et al, 2007) : depresión, ansiedad, funcionamiento global, y funcionamiento social, tendencias suicidas, ira y impulsividad, irritabilidad, asalto verbal, y el asalto directo, apego más seguro y una mayor capacidad reflexiva (Levy et al, 2006.)

Leicshering et al., The Lancet 2011

Terapias cognitivas comportamentales

1. **SCHEMA-FOCUSED THERAPY. (**Jeffrey Young , 2003).

Objetivo: El cambio se logra a través de una amplia gama de comportamiento, y técnicas que se centran en la relación terapéutica, la vida cotidiana fuera de la terapia, y las experiencias pasadas (incluyendo experiencias traumáticas). La recuperación de SFT se logra cuando los esquemas disfuncionales ya no controlan la vida del paciente. (Giesen-Bloo Arch Gen Psych 2006).

- 3-años de seguimiento: la psicopatología límite, la psicopatología en general, la calidad de vida. Una reducción significativamente mayor en la gravedad de los síntomas en seis de los nueve criterios DSM-IV para el TLP (cada uno de los síntomas de tipo cognitivo, impulsivo e interpersonales): alteración de la identidad, la disociación / paranoia, actos auto destructivos, impulsividad, miedo al abandono, y relaciones tormentosas. Sin embargo, no hay mejorias significativas en ninguno de los tres criterios DSM-IV para los sintomas afectivose del TLP : la ira, el vacío, o cambios de humor.

2. **DIALECTICAL BEHAVIORAL THERAPY. (**Linehan , 1993)

Objectivo: manejar la desregulación emocional. (Linhean , Arch Gen Psych 2006-1993-1994)

- 1 año de seguimiento: la reducción de comportamiento parasuicida (automutilación e intentos de suicidio), significativamente menos días en el hospital.
- 2 años de seguimiento: menos intentos de suicidio, menos ira, y mejor ajuste social, significativamente menos días de hospitalización psiquiátrica.

Leicshering et al., The Lancet 2011

Limit

Terapia dialetico-conductal:
riesgo de suicidio a 2 años de seguimiento

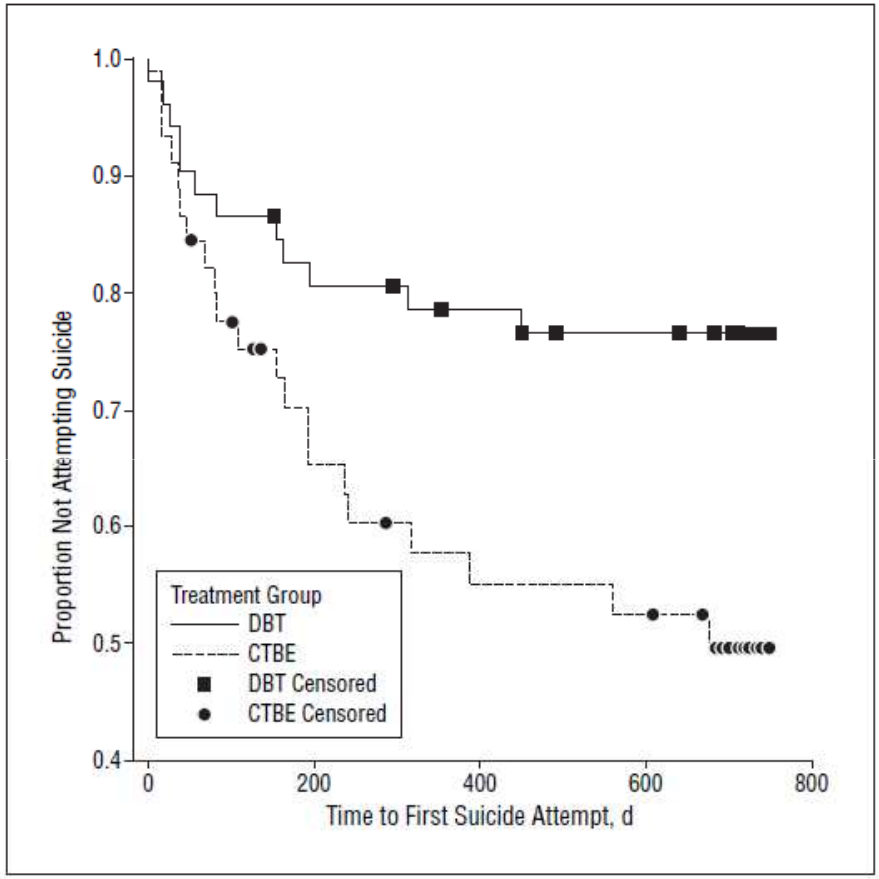
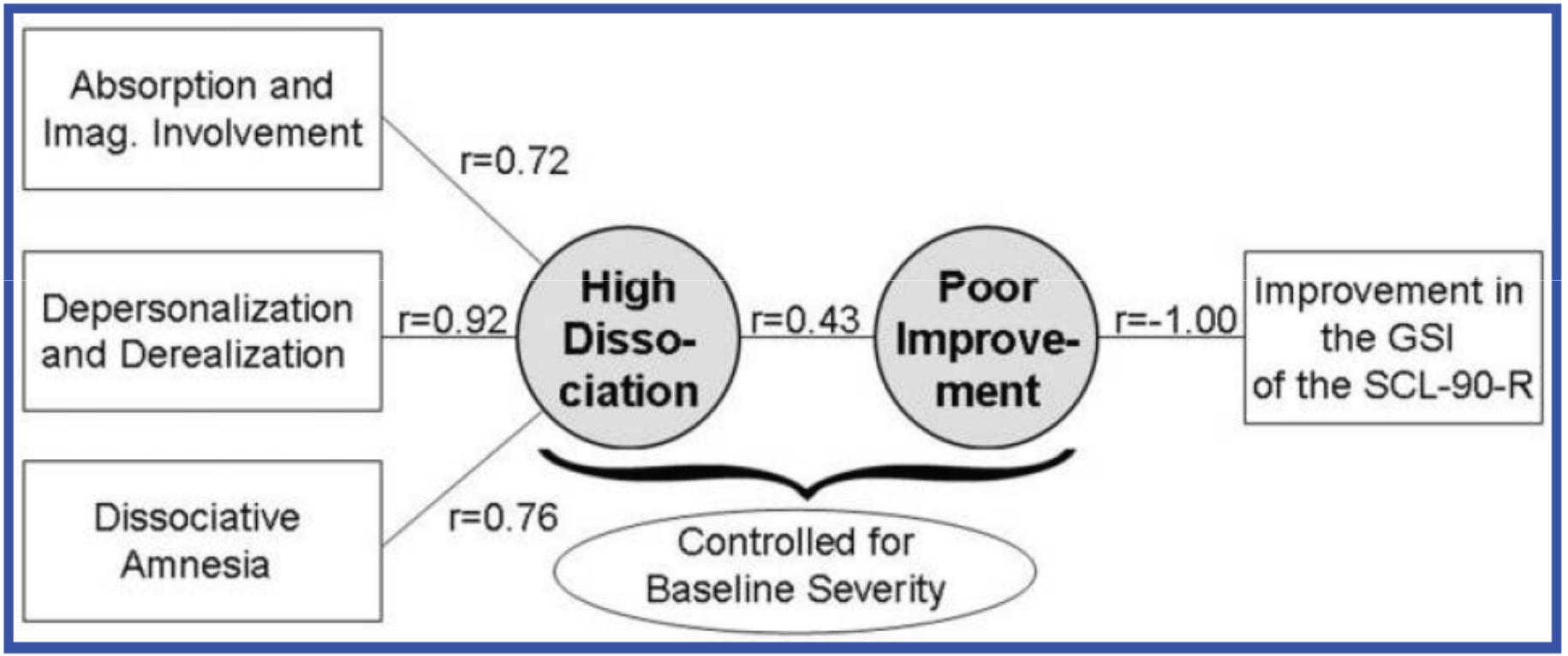


Figure 3. Survival analysis for time to first suicide attempt. The treatment period ended at 365 days, and the follow-up period ended at 730 days. CTBE indicates community treatment by experts; DBT, dialectical behavior therapy.

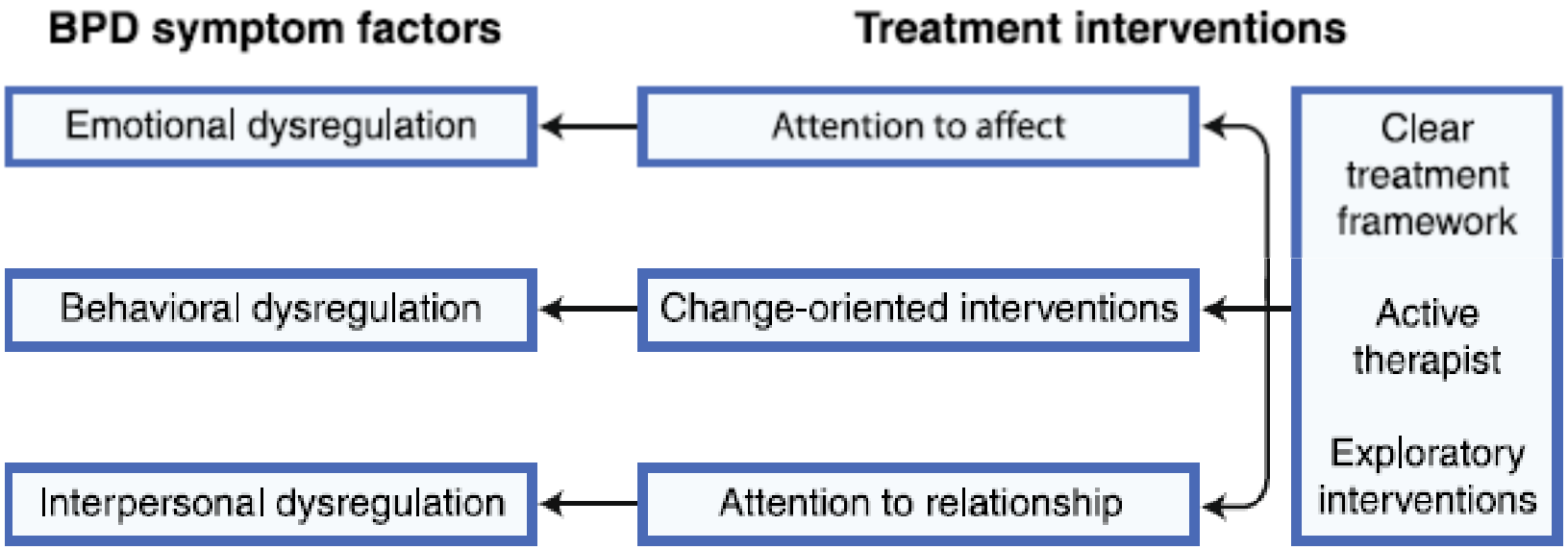
Linehan , Arch Gen Psych 2006

Terapia dialetico-conductal:
el papel de los síntomas disociativos



Kleindienst, J Pers Dis 2011

Similitudes entre las psicoterapias

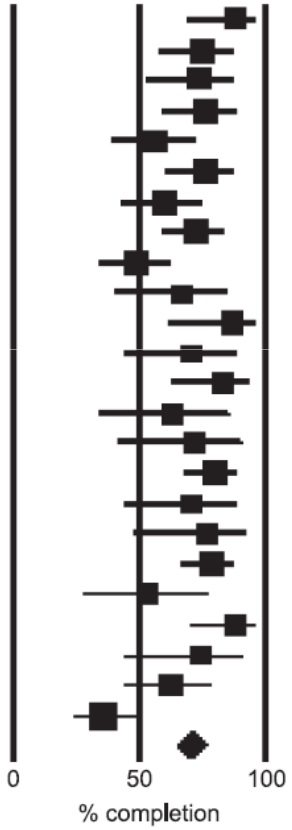


Weinberg et al., Curr Psych Rep 2011

La finalización del tratamiento y los factores asociados con el *drop-out* en la psicoterapia

Table 3. Meta-analyses of completion rates in psychotherapy for borderline personality disorder – intervention length 12 months or longer

First author and date	Treatment	Sample initiating treatment (N)	Treatment completion (%)
Bateman 1999 (39)	MBT	25	88
Brown 2004 (51)	CBT	32	75
Clarkin 2001 (52)	TFP	23	74
Clarkin 2007 (44)	TFP	30	77
Clarkin 2007 (44)	DBT	30	57
Comtois 2007 (54)	DBT	38	76
Cottraux 2009 (55)	CBT	33	69
Giesen-Bloo 2006 (40)	SFT	45	73
Giesen-Bloo 2006 (40)	TFP	43	49
Gregory 2008 (37)	DDP	15	67
James 2008 (59)	DBT	16	88
Kennedy 2007 (60)	DBT	14	71
Linehan 1991 (30)	DBT	24	81
Linehan 1999 (31)	DBT	11	63
Linehan 2002 (34)	DBT	11	73
Linehan 2006 (36)	DBT	52	83
Lopez 2004 (63)	TFP	14	71
Low 2001 (64)	DBT	13	77
Nadort 2009 (65)	SFT	62	85
Nee 2005 (66)	DBT	13	54
Perseius 2007 (67)	DBT	27	89
Turner 2000 (32)	DBT	12	75
Verheul 2003 (35)	DBT	27	63
Zinkler 2007 (75)	DBT	50	36
Overall estimate			71



CBT, cognitive behaviour therapy; DBT, dialectical behaviour therapy; DDP, dynamic deconstructive psychotherapy; MBT, mentalisation-based therapy; TFP, transference-focused therapy.

Barnic ot et al., Act Psyc Scand 2011

Limit

Tratamiento farmacologico

	Treatment	Mean dose
Bogenschutz et al[95]	Olanzapine vs placebo	6·9 mg per day
de la Fuente et al[92]	Carbamazepine vs placebo	Blood concentration 6·4–7·1 µg/mL
Frankenburg et al[82]	Sodium valproate vs placebo	850 mg per day
Goldberg et al[87]	Tiotixene vs placebo	8·7 mg per day
Hollander et al[33]	Sodium valproate vs placebo	Blood concentration 64·6 µg/mL
Hollander et al[34]	Sodium valproate vs placebo	1325 mg per day
Leone et al[88]	Loxapine vs placebo	14·4 mg per day
Leone et al[88]	Chlorpromazine vs placebo	110 mg per day
Pascual et al[100]	Ziprasidone vs placebo	81 mg per day
Reich et al[96]	Lamotrigine vs placebo	25–275 mg per day
Rinne et al[84]	Fluvoxamine vs placebo	150 mg per day
Salzman et al[85]	Fluoxetine vs placebo	40 mg per day
Schulz et al[97]	Olanzapine vs placebo	2·5–20 mg per day
Shafti and Shahveisi[98]	Olanzapine vs haloperidol	2·5–10 mg per day
Soloff et al[94]	Haloperidol vs amitriptyline vs placebo	4·8 mg per day; 149·1 mg per day
Soloff et al[93]	Haloperidol vs phenelzine sulfate vs placebo	3·9 mg per day; 60·45 mg per day
Zanarini et al[90]	Olanzapine vs placebo	5·3 mg per day
Zanarini et al[35]	Omega-3 fatty acids vs placebo	1 mg per day
Zanarini et al[91]	Olanzapine vs fluoxetine vs olanzapine plus fluoxetine	3·3 mg per day; 15·0 mg per day; 3·2 mg per day plus 12·7 mg per day
Ziegenhorn et al[99]	Clonidine vs placebo	0·45 mg per day

Table 1: **Randomised controlled trials of pharmacotherapy in patients with borderline personality disorder**

Leicshering et al., The Lancet 2011