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FAMILY THERAPY AS ADDITION TO INDIVIDUAL THERAPY AND PSYCHOPHARMACOTHERAPY IN LATE ADOLESCENT FEMALE PATIENTS SUFFERING FROM BORDERLINE PERSONALITY DISORDER WITH COMORBIDITY AND POSITIVE SUICIDAL HISTORY

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SUMMARY

The treatment of patients with BPDs is more hopeful than it was in the past. During the past period, psychiatrists have become overly dependent on pharmacological treatments, neglecting psychotherapies even when they are evidence-based. There is much stronger evidence for the effectiveness of psychotherapy in BPD than for any pharmacological intervention. One of the important psychotherapy for BPD is family therapy. Our work emphasized the protective role of family therapy in late adolescent female patients suffering from borderline personality disorder with eating disorder comorbidity.

Key words: *borderline personality disorder – suicidality - eating disorder – women - family psychotherapy - psychoanalytic psychotherapy*

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Borderline personality disorder (BPD), comorbidity and suicidality

Comorbidity is often presented in BPD patients. Very important facts for clinicians are to assess comorbidity for every patient and not avoid making Axis II diagnoses, or only diagnose PD patients without comorbid Axis I conditions, because they are likely to be disappointed with the results of drug treatment. Affective disorder is probably the most common of these comorbidities and may present as major depression or bipolar disorder (Marčinko & Vuksan-Ćusa 2009). In female more than in male patients, eating disorders, including anorexia nervosa, bulimia nervosa, or alternating bouts of both, another common accompaniment. Numerous data emphasized that comorbidity in BPD patients is a contributor to heightened risk for aggressive and suicidal behavior. For prescribing an optimal treatment plan for patients with BPD is necesssary to assess all components of comorbidity. Psychotherapeutic treatment of individuals with BPD and comorbidity is one of the most difficult challenges that clinicians encounter. Treatment is further complicated when individuals with BPD become suicidal. Among psychotherapies, numerous evidence confirmed efficacy of psychoanalytic psychotherapy, mentalization-based therapy and dialectical-behavioral therapy (Kernberg 2001). In our earlier paper, we have emphasized the role of countertransference in the therapy of suicidal patients (Marčinko et al. 2008a) as an important part of integrative treatment in psychiatry (Jakovljević 2008).

The limited role of psychopharmacotherapy for BPD

A wide variety of pharmacological agents reduce impulsivity in personality disorders, but these drugs are of limited value because they were developed for other purposes, and are applied to Axis II diagnoses that probably have a different pathophysiology (Paris 2008). Limited therapeutic effects of psychopharmacotherapy have been shown in study concerning BBD and comorbid diagnoses. Depressed patients who also have personality disorder (PD) do not respond to the same treatment methods (whether pharmacological or psychotherapeutic) as those without PD (Shea et al. 1990). Some studied linked this conclusion in relation to antidepressants (Mulder 2004), meta-analysis by Newton-Howes et al. (2006) supported it. According to World Federation of Societies of Biological Psychiatry (WFSBP) Guidelines for Biological Treatment of Personality Disorders (Herpertz et al. 2007) no class of pharmacological agents improves BPD psychopathology in general, although the majority of studies have incorporated measurements of global functioning in addition to targeting special aspects of psychopathology. In addition, there is no conclusive evidence that antidepressants reduce impulsive, aggressive or self-harming behaviors in BPD. The core of the treatment for BPD is still psychotherapy. The main technical approaches fall into three broad categories: (1) supportive psychotherapy, (2) psychoanalytically informed psychotherapy, and (3) cognitive-behavioral psychotherapy. Each of these categories may be subclassified.

Suicidality in BPD - the role of neurobiology and psychotherapy

The psychotherapeutic treatment of suicidal patients with BPD is one of the biggest challenges facing mental health professionals (Marčinko et al. 2008a, Marčinko 2010). Suicidality in BPD peaks when patients are in their early 20s, but completed suicide is most common

after 30 years of age and usually occurs in patients who fail to recover after many attempts or treatment (Paris 2003). The neurobiology of suicide in patients with BPD is still unclear. Changes in serum concentration of lipids, particularly of cholesterol, are among the most studied biological factors in the field of suicidality. The importance of cholesterol for physical and psychological well-being has been recognized for several decades (Jakovljević et al. 2007). According to the highly cited Engelberg's hypothesis (1992), low serum cholesterol levels may be associated with reduced lipid micro-viscosity in the brain-cell-membrane and may decrease the exposure of various serotonergic receptors on the membrane surface, resulting in decreased serotonergic receptor function and inhibited serotonergic neurotransmission, which may lead to a poorer suppression of impulsive or suicidal behavior. Our previous studies confirmed the role of cholesterol in suicidal behavior, showing lower cholesterol levels in suicidal patients with different forms of psychotic disorders (Marčinko et al. 2004, 2005, 2007a, 2007b, 2008b) and bipolar affective disorder (Vuksan-Ćusa et al. 2009), which are frequent comorbidity in patients with BPD (Marčinko & Vuksan-Ćusa 2009). Contrary to these series of studies, our investigation regarding suicidality in BPD (Marčinko et al. 2010-in press), shows a lack of significant differences in total serum cholesterol levels between suicidal borderline patients compared to non-suicidal patients with BPD and healthy control subjects. This finding might be associated with the mentioned biologic theory of a poorer response of BPD patients to antidepressants acting via serotonergic system compared to the patients with the other diagnostic categories (Shea 1990). The other result of the study confirmed that structured individual psychoanalytic psychotherapy prior to the hospitalization significantly decreased suicidal behavior, since male patients suffering from BPD, who received this type of psychotherapy, did not show suicidal behavior. The role of structured individual psychoanalytic psychotherapy is to enhance patient's personality and to help patient to better cope with BPD symptoms. This therapy might also help patients to better control symptoms of anxiety, depression, grandiosity, tension, excitement and motor hyperactivity, which were presented more severely in suicidal patients with BPD, and to control suicidal symptoms, in order to prevent suicidal behavior.

Family therapy for borderline personality disorder

Family therapy for borderline personality disorder (BPD) may be a helpful addition to traditional BPD treatment plan which include individual therapy, group therapy and psychopharmacotherapy. Family members of people with BPD frequently report feeling overwhelmed by their loved ones' symptoms, and often need help understanding where these symptoms come from and how they are best managed. According to American Psychiatric Association Practice guideline for the treatment of patients with borderline personality disorder (2001), data on family therapy are limited; they suggest that a psychoeducational approach may be beneficial. They also reported that published clinical reports differ in their recommendations about the appropriateness of family therapy and family involvement in the treatment; family therapy is not recommended as the only form of treatment for patients with borderline personality disorder. They recommended, psychoeducation for families should be distinguished from family therapy, which is sometimes a desirable part of the treatment plan and sometimes not, depending on the patient's history and status of current relationships. Family therapy is a bit different than the traditional kind of psychotherapy that most people are familiar with. Rather than just one person (such as the person with BPD) and their therapist, family therapy involves the whole family, working together, with one or two therapists. Family therapy typically involves the immediate family (such as parents, spouses, siblings), but can also include extended family when appropriate. Adolescents often have conflicts with their parents, which can disturb or endanger the equilibrium of family functioning (Rudan 1996). Family therapy is usually suggested when either the BPD symptoms are negatively impacting the functioning of the family, or when problems in the family may be making the BPD symptoms worse. Sometimes these two problems interact - the BPD symptoms impair family functioning, and poor family functioning makes the BPD symptoms worse. This kind of vicious cycle can be addressed in family therapy. Only few researches have been done to examine whether family therapy for BPD reliably reduces BPD symptoms or improves family functioning. Case reports and other studies suggest that this type of therapy can lead to better communication, less conflicts, and fewer feelings of burden and guilt in BPD families. Many clinicians suggest that this approach is particularly helpful with BPD adolescents or other individuals who are still dependent on their families (such as living at home or getting significant support from family members).

Preliminary results of our study: Family therapy in late adolescent female patients suffering from borderline personality disorder and eating disorder with positive suicidal history

Comorbidity and suicidality is frequent problem in patients suffering from borderline personality disorder. Therapy of these patients is a great challenge for the psychiatrists. Our study has compared the differences in personality factors (TCI), depression (Beck Depression Inventory), suicidality (SUAS) and family dynamics (FACES), between two groups of late adolescent female patients with positive suicidal history treated at the

Psychiatric Clinic of University Hospital Center Zagreb, during 12 months. The first group includes 15 female patients, diagnosed by borderline personality disorder and comorbid eating disorder, which have been treated by individual therapy and psychoanalytically oriented family therapy. The second group includes 15 female patients, diagnosed by borderline personality disorder and comorbid eating disorder, which have been treated only by individual therapy, without family therapy. All included patients had positive history of suicidal behavior. At the beginning of the study, there were no significant differences between groups in socio-demographic parameters, psychopharmacotherapy, personality factors, suicidality, depression and family dynamics. The results indicated that patients treated by family therapy showed significant improvement in harm avoidance, self-directedness, depression and suicidality compared to group without family therapy. Family dynamic also changed in these patients. Results of investigation emphasized the role of family therapy in reducing self destructive patterns of behavior in female patients suffering from borderline personality disorder and eating disorder. The first complete results of our study, concerning the impact of family therapy in female patients suffering from borderline personality disorder and eating disorder with positive suicidal history, will be presented at the 1st International Congress on Borderline Personality Disorder (1-3 July 2010, Berlin) (Marčinko 2010).

Summary - the importance of combined treatment

The clinical management of borderline personality disorder (BPD) commonly involves treatments administered in different settings by different clinicians (e.g., individual psychotherapy and psychopharmaco-therapy, or individual and family psychotherapies). The general consensus of clinicians on the importance of using different therapists and different settings simultaneously in treating borderline patients is acknowledged by the guidelines for the treatment of BPD provided by the American Psychiatric Association. The treatment of patients with BPDs is today more hopeful than it was in the past. During the past period, psychiatrists have become overly dependent on pharmacological treatments, neglecting psychotherapies even when they are evidence-based. There are much scientific evidence that support association between psychoanalytic therapies and neuroscientific data regarding psychopharmacotherapy (Rudan et al. 2008). There is much stronger evidence for the effectiveness of psychotherapy in BPD than for any pharmacological intervention. One of the important psychotherapy for BPD is family therapy. Our work emphasized the protective role of family therapy for BPD female patients with eating disorder comorbidity.

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