

Stigma and Borderline Personality Disorder

Federal Partners Meeting on Borderline Personality Disorder
Co-sponsored by National Alliance on Mental Illness &
National Educational Alliance for BPD
Rockville, MD – November 9, 2011

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Personality “Order” or “Disorder”

- Q** Since everyone has a personality, how do we decide what a personality disorder is?

- A** Having too much or too little of normal traits can cause problems in functioning (like high blood pressure or low blood pressure).

DSM-IV Definition of Personality Disorder

An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture. This pattern is manifested in two (or more) of the following areas:

1. Cognition
2. Emotions
3. Interpersonal functioning
4. Impulse control

Borderline Personality Disorder (BPD)

APA DSM-IV Criteria

(At least 5 must be present)

1. Fear of abandonment
2. Difficult interpersonal relationships
3. Uncertainty about self-image or identity
4. Impulsive behavior
5. Self-injurious behavior
6. Emotional changeability or hyperactivity
7. Feelings of emptiness
8. Difficulty controlling intense anger
9. Transient suspiciousness or “disconnectedness”

Prevalence of Borderline Personality Disorder

- General population 5.9%*
- Mental health outpatient 11%
- Mental health inpatient 19%
- Primary care 6%

* Grant B, *J Clin Psychiatry*, 2008

Comorbidity

- 84.5% of BPD patients met criteria for Axis I disorder, mean = 3.2
- Most common =
 - Mood disorders
 - Anxiety disorders
 - Substance use disorders

Patients with BPD Have Severe Impairment in Functioning

- Common history of childhood trauma
- Mistrustful of others, yet cling to others for “life support”
- High internal levels of anxiety and distress
- Stormy interpersonal relationships
- High family stress
- Difficulty keeping jobs
- Overemotional and impulsive
- Self-injurious behavior

High Suicide Risk in Patients with BPD

8 – 10 % commit suicide

60 – 70 % make suicide attempts

Worldwide Magnitude of Psychiatric Disability



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SUMMARY

GLOBAL BURDEN OF DISEASE AND INJURY SERIES



THE GLOBAL BURDEN OF DISEASE

EDITED BY
CHRISTOPHER J. L. MURRAY
ALAN D. LOPEZ



WORLD HEALTH
ORGANIZATION



HARVARD SCHOOL OF
PUBLIC HEALTH



WORLD
BANK

The Global Burden of Disease

Results: The Unseen Burden of Psychiatric Disease

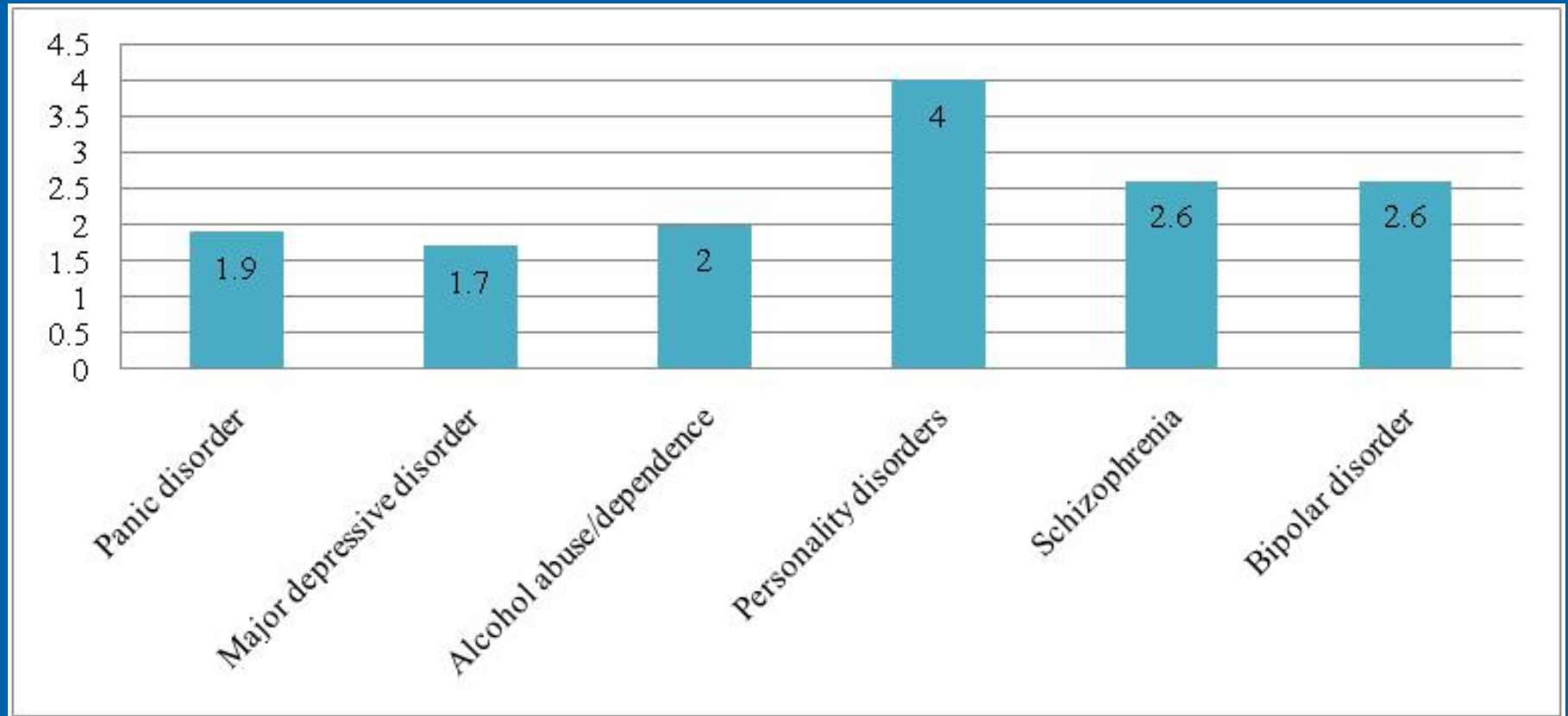
“Most significantly, the study shows that the burden of psychiatric conditions has been heavily underestimated. Of the ten leading causes of disability worldwide in 1990, measured in years lived with a disability, five were psychiatric conditions.”

“The burden of mental illnesses, such as depression, alcohol dependence and schizophrenia, have been seriously underestimated by traditional approaches.”

The Leading Causes of Disability - World, 1990

All Causes	Total (millions) 472.7	% of total
1. Unipolar major depression	50.8	10.7
2. Iron-deficiency anaemia	22.0	4.7
3. Falls	22.0	4.6
4. Alcohol use	15.8	3.3
5. Chronic obstructive pulmonary disease	14.7	3.1
6. Bipolar disorder	14.1	3.0
7. Congenital anomalies	13.5	2.9
8. Osteoarthritis	13.3	2.8
9. Schizophrenia	12.1	2.6
10. Obsessive-compulsive disorders	10.2	2.2

Mortality Burden of Mental Disorders



From Eaton et al., 2008 (literature review)

APA Task Force on Borderline Personality Disorder (1989)

BPD

- Treatment is difficult
- Severe countertransference problems are common
- Outcome is variable

Greatest Stressors for Professionals

1. Patient anger
2. Suicide attempts
3. Threats of suicide

Hellman et al., 1988

Treatment Outlines for Borderline, Narcissistic and Histrionic Personality Disorders

The Quality Assurance Project
(Quality Assurance in Aspects of Psychiatric
Practice is a project under the aegis of the Royal
Australian and New Zealand Department of Health)

Australian and New Zealand Journal of Psychiatry 1991; 25:392-403

Australian / New Zealand Study

- Questionnaire sent to all 1356 psychiatrists in Australia; 715 responded
- 254 responded to Borderline vignette
 - 80% saw such patients in practice
 - 40% would not treat
 - 5% felt there was no treatment for this disorder

Challenges in Developing Psychiatric Practice Guidelines

APA / NIMH

Washington, D.C.

September 21 & 22, 1992

Day 1
Monday, September 21, 1992

Practice-Based Research in Psychiatry:
Methodologic Issues

Deborah Zarin, Chair

Day 2

Tuesday, September 22, 1992

New Methods in Guideline Development:
What to do When the Database is Incomplete

John Oldham, Chair

American Psychiatric Association Practice Research Network

- Informal Survey, 1992
- Reported BPD prevalence estimated at 0.05%

A Proposal for Practice Guidelines for Borderline Personality Disorder

John G. Gunderson, MD
September 1996

1. Overall Treatment Structure
2. Psychotherapy
3. Pharmacotherapy

A Report of the Surgeon General on Mental Health 1999

1. Mental health is fundamental to health.
2. Mental disorders are real health conditions.
3. The efficacy of mental health treatments is well documented.
4. A range of treatments exists for most mental disorders.

- “About one in five Americans experiences a mental disorder in the course of a year. Approximately 15 percent of all adults who have a mental disorder in one year also experience a co-occurring substance (alcohol or other drug) use disorder....”

Surgeon General’s Report on Mental Health

- “...nearly half of all Americans who have a severe mental illness do not seek treatment.”
- “...effective treatments for mental disorders promise to be the most effective antidote to stigma.”

Surgeon General’s Report on Mental Health

APA Practice Guidelines Work Group on Borderline Personality Disorder

John Oldham, M.D. (Chair)

Glen Gabbard, M.D.

Marcia Goin, M.D., Ph.D.

John Gunderson, M.D.

Paul Soloff, M.D.

David Spiegel, M.D.

Michael Stone, M.D.

Katherine Phillips, M.D.

Psychotherapy Recommendations for BPD

1. Dialectical behavior therapy

RCT: Linehan et al.

Archives Gen Psych, 1991

AJP, 1994

Am J Addictions, 1999

Clinical consensus: Strong

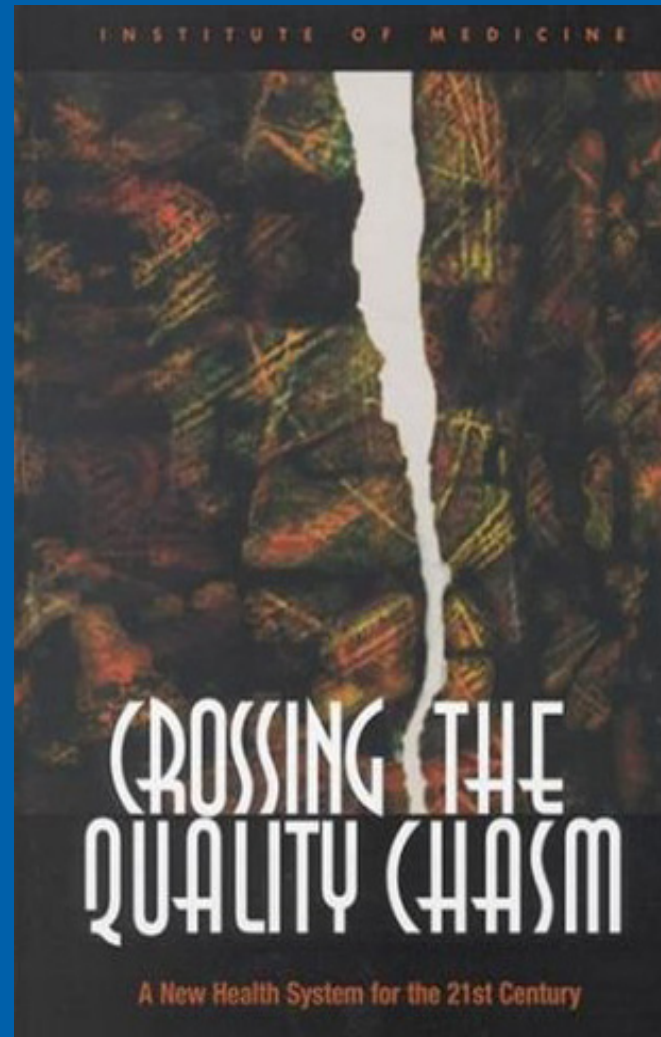
2. Psychoanalytic/psychodynamic therapy

RCT: Bateman & Fonagy, AJP, 1999

Clinical consensus: Strong



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Institute of Medicine, Improving the quality of health care for mental and substance-use conditions: Quality Chasm Series, November 2005.

- Only 24% of 21 studies documented adequate adherence to specific recommendations in clinical practice guidelines

Types of Psychotherapy for BPD

1. Dialectical Behavior Therapy (DBT)
2. Mentalization-Based Therapy (MBT)
3. Schema-Focused Therapy (SFT)
4. Transference-Focused Therapy (TFT)
5. Cognitive Behavioral Therapy (CBT)
6. Systems Training for Emotional Predictability and Problem Solving (STEPPS)
7. General Psychiatric Management (GPM)

Imagine the Impact of This

“Borderline Personality Disorder: The Disorder
that Doctors Fear Most”

- Cover, Time Magazine January 19, 2009

JANUARY 19, 2008



Jeffrey Sachs: How
More Government
Can Save America

Borderline Personality:
The Disorder That
Doctors Fear Most



Can Apple
Make It Without
Steve Jobs?

TIME



Why Israel Can't Win

The siege of Gaza may punish Hamas,
but it won't make Israel safe.
Why it is in peril like never before
BY TIM MCGIRK

PLUS: How Obama
can forge a Middle East peace
BY MARTIN INDIK

www.time.com

Personality Disorders in the Military

- Personality disorders usually lead to administrative separation
- Long term psychotherapy is not usually feasible
- Administrative channels vs. medical channels

Col. Rick Malone, MD, MPH
Walter Reed Army Medical Center

Administrative Separation

- “Fit but unsuitable” for military service
- Usually honorable discharge
- No severance package
- Usually not qualified for VA medical benefits

Col. Rick Malone, MD, MPH
Walter Reed Army Medical Center

Personality disorders are considered “Existing Prior to Service” or “Existing Prior to Enlistment” and are referred for administrative separation.

Col. Rick Malone, MD, MPH
Walter Reed Army Medical Center

Should the Name be Changed?

“Borderline personality disorder by any other name would still be as real, as disabling, and as necessary to treat, as other serious mental illnesses.”

- Thomas Insel, MD
Director, National Institute of Mental Health
Director's Post, April 19, 2010

Personality Disorders DSM-5 Work Group

Andrew Skodol, MD, *Chair*

Renato Alarcon, MD

Carl Bell, MD

Donna Bender, PhD

Lee Anna Clark, PhD

Robert Krueger, PhD

John Livesley, MD

Leslie Morey, PhD

John Oldham, MD

Larry Siever, MD

Roel Verheul, PhD

Four Essentials of Effective BPD Treatment

1. Establishment of a strong therapeutic alliance
2. Availability of skilled therapists
3. Funds / insurance coverage
4. Time

NOTE: THERE IS NO QUICK FIX

“Psychiatric services are devalued by third-party payers with ridiculously low reimbursement, high co-payments, and arbitrarily meager annual or lifetime caps. Insurance executives often foolishly decide psychotherapy is not worth paying for despite its enormous value to many patients.”

Henry A. Nasrallah, MD, *Current Psychiatry*, 2011

Coverage for BPD Treatment

- BPD is covered by most plans
- There needs to be a medically necessary reason for treatment

Pamela Greenberg
President and CEO, Association for
Behavioral Health and Wellness;
President, American College of Mental Health
Administration
(October, 2011)

The Good News

- BPD is treatable
- Treatment works
- With good treatment, and enough time, patients get better

A Final Word on Stigma

World Psychiatric Association Guidance on How To Combat Stigmatization of Psychiatry and Psychiatrists

Recommendations:

- National psychiatric organizations should define best practices of psychiatry and actively pursue their application in the mental health care system
- National psychiatric organizations, in collaboration with relevant academic institutions, should revise the curricula for undergraduate and postgraduate medical training
- National psychiatric societies should establish closer links and collaboration with other professional societies, with patients and family associations and with other organizations that can be involved in the provision of mental health care and the rehabilitation of the mentally ill
- National psychiatric societies should seek to establish and maintain sound working relationships with the media
- Psychiatrists must be aware that their behavior can contribute to the stigmatization of psychiatry as a discipline and of themselves as its representatives

The Problem of Stigma

- Active duty military reluctant to ask for mental health help. Seen as “weaklings” or blocked from return to duty.
- Even in military treatment centers, patients can be seen critically, as weak or faking illness

A Final Word on Stigma (continued)

In addition to education about treatment that works, we need the strong collective voice of “champions” to speak publically about overcoming, and living successfully with, psychiatric disorders

For example,



Kay Redfield Jamison, PhD

“It was difficult to make the decision to be public about having a severe psychiatric illness... but privacy and reticence can kill. The problem with mental illness is that so many who have it—especially those in a position to change public attitudes, such as doctors, lawyers, politicians, and military officers—are reluctant to risk talking about mental illness, or seeking help for it. They are understandably frightened about professional and personal reprisals”

And,



Marsha Linehan, PhD

“Dr. Marsha Linehan does a great service to millions of Americans who suffer from mental illness. As Dr. Linehan so movingly illustrates, people with psychiatric disorders are not so different from people with other medical conditions such as diabetes or heart disease—they are our friends, teachers, doctors, neighbors, and loved ones. Because of the stigma still felt about seeking treatment, however, those struggling with psychiatric problems often suffer in silence.”

John M. Oldham, MD
Letter to the New York Times, 2011

Thank you for your interest!