

Good Psychiatric Management of BPD: Overview for NEABPD

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**“Good Psychiatric Management of BPD:
What everyone needs to know”**

Section 1: Background/Overall Principles

**Borderline patients
should be able to assume
that professionals who
treat them have been
trained to do so.**

Overview

- **Treatment of BPD is not done consistently or well**
- **Most clinicians don't like treating BPD patients**
- **There is a shortage of well-trained BPD treaters**

A Randomized Trial of Dialectical Behavior Therapy Versus General Psychiatric Management for Borderline Personality Disorder

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Objective: The authors sought to evaluate the clinical efficacy of dialectical behavior therapy compared with general psychiatric management, including a combination of psychodynamically informed therapy and symptom-targeted medication management derived from specific recommendations in APA guidelines for borderline personality disorder.

Method: This was a single-blind trial in which 180 patients diagnosed with borderline personality disorder who had at least two suicidal or nonsuicidal self-injurious episodes in the past 5 years were randomly assigned to receive 1 year of dialectical behavior therapy or general psychiatric management. The primary outcome measures, assessed at baseline and every 4 months over the treatment period, were frequency and severity of suicidal and nonsuicidal self-harm episodes.

Results: Both groups showed improvement on the majority of clinical outcome

measures after 1 year of treatment, including significant reductions in the frequency and severity of suicidal and nonsuicidal self-injurious episodes and significant improvements in most secondary clinical outcomes. Both groups had a reduction in general health care utilization, including emergency visits and psychiatric hospital days, as well as significant improvements in borderline personality disorder symptoms, symptom distress, depression, anger, and interpersonal functioning. No significant differences across any outcomes were found between groups.

Conclusions: These results suggest that individuals with borderline personality disorder benefited equally from dialectical behavior therapy and a well-specified treatment delivered by psychiatrists with expertise in the treatment of borderline personality disorder.

(*Am J Psychiatry* 2009; 166:1365–1374)

Borderline personality disorder has a prevalence of 1%–2% (1) and is associated with considerable morbidity and mortality, leading to substantial costs through premature death and high health care utilization (2). An estimated 69%–80% of patients with this disorder attempt suicide (3, 4), and a higher percentage engages in nonsuicidal self-injurious behavior, which is itself a risk factor for suicide. The rate of completed suicide in this group is approximately 10% (5).

Until recently, borderline personality disorder was viewed as untreatable. Over the past 15 years, several studies have established the efficacy of different forms of psychotherapy in reducing core features of the disorder. Of the six psychotherapy approaches supported by empirical evidence (6–17), dialectical behavior therapy has been the most studied. The first three of five published randomized controlled trials compared dialectical behavior therapy and treatment as usual and demonstrated its superiority in treatment retention and reducing suicidal behaviors (6, 7, 18). Two recent trials compared it with alternative rigorous psychotherapies; one demonstrated its superior-

ity (8) relative to psychotherapy delivered by experts, and the other found that it was generally equivalent to structured treatments for borderline personality disorder on the main outcome measures—depression, anxiety, global functioning, and social adjustment (12).

Given the growing empirical base, dialectical behavior therapy represents the current standard treatment for borderline personality disorder. However, more definitive information is needed regarding its efficacy relative to robust treatments delivered by clinicians with expertise in treating this patient population. There is also a need for large-scale replication studies conducted independently of the treatment developer. In this study, we compared dialectical behavior therapy and general psychiatric management, an active, manualized approach derived from APA recommendations (19) including a combination of psychodynamically informed therapy and symptom-targeted medication management. We hypothesized that participants receiving dialectical behavior therapy would show greater reductions in the frequency and severity of suicidal and nonsuicidal self-injurious behaviors. This

This article is the subject of a [CME](#) course (p. 1437).

GENERAL PSYCHIATRIC MANAGEMENT (GPM): RCT

(McMain & Links, AJP 2009)

- **Outcome equals DBT: ↓ DSH, hospitalizations, depression**
- **Therapists: > 5 years experience; guided by Gunderson & Links' BPD: A Clinical Guide (2008); met as group with Links**

GENERAL PSYCHIATRIC MANAGEMENT

(GPM): Structure

- **Once weekly individual (if useful)**
- **Psychodynamic (unrecognized motives, feelings; defenses related to IHS) & behavioral (accountability, contingencies)**
- **Often includes medication management**
- **Work > love**
- **Split treatments desired**
- **PRN family interventions**

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**Section 2: Interpersonal Hypersensitivity:
theory and usage**

INTERPERSONAL HYPERSENSITIVITY **AS CORE**

- **BPD has a unifying latent genetic core (~ 55% H)**
- **Interpersonal features are the most discriminating**
- **Interpersonal events predict remissions/relapses, SIB, dissociation, suicide**
- **BPD has elevated cortisol and HPA reactivity and neurohormone deficits**
- **Childhood disorganized attachments, separation problems, and hypersensitivity predict adult BPD**

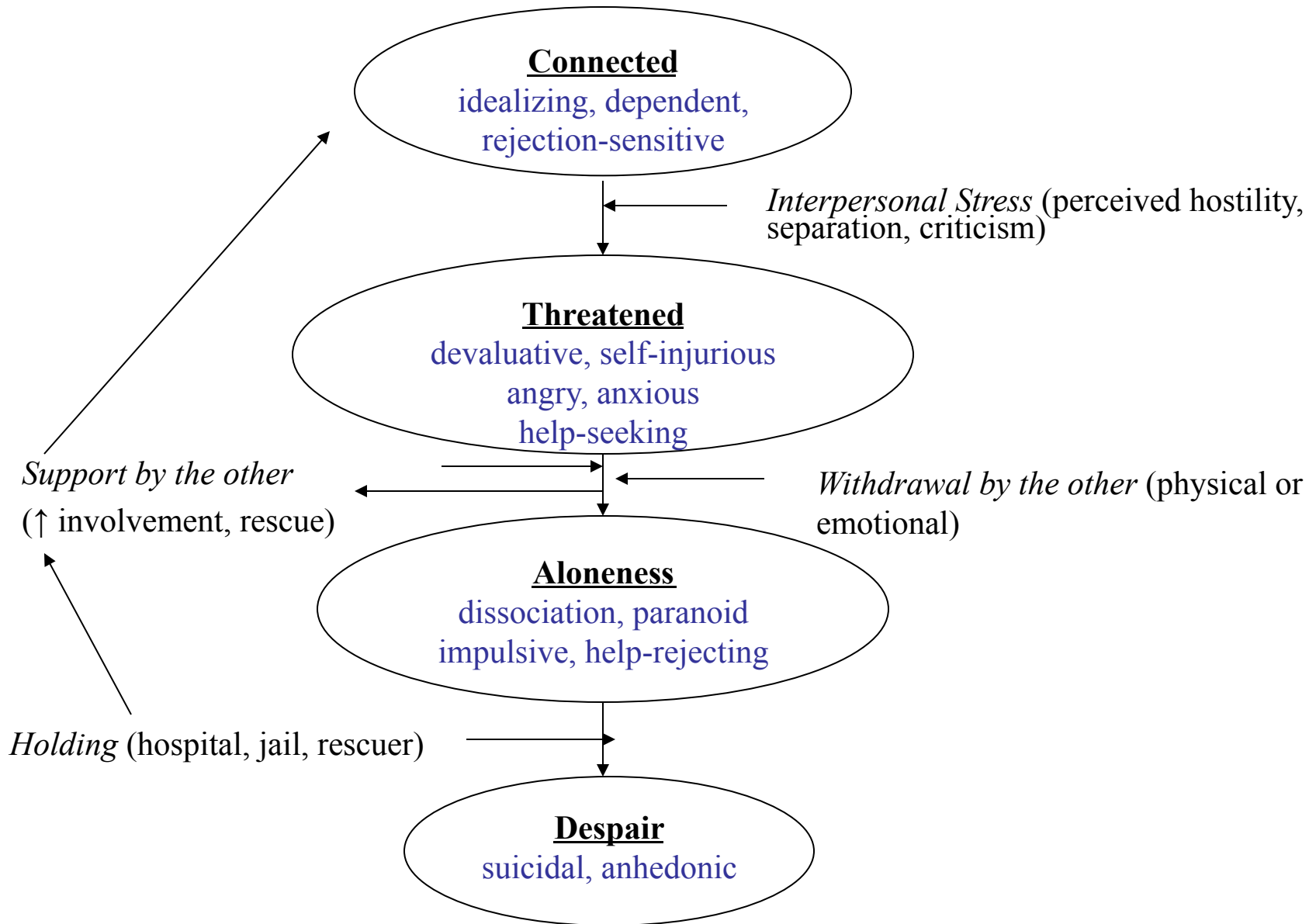
BPD' s DIAGNOSTIC COHERANCE

**HELD (*ATTACHED*) - DEPRESSED,
REJECTION-SENSITIVE, IDEALIZING,
COLLABORATIVE**

**THREATENED (*ACTIVATED SYSTEM*)
- ANGRY, SELF-PUNITIVE, MANIPULATIVE,
DEVALUATIVE**

**ALONE (*PRIMITIVE COGNITION*)
- DISSOCIATED, PARANOID, DESPERATELY
IMPULSIVE**

BPD's INTERPERSONAL COHERENCE



GPM AND INTERPERSONAL **HYPERSENSITIVITY**

- **patients sensitivity/reactivity to being “held”
predicts/explains phenomenology**
- **dynamics:**
 - a) unacceptable anger or passivity → “badness”**
 - b) attachment = dependency, exploitation or
inseparability, agreement**
 - c) emotional/behavioral dyscontrol 2°
interpersonal stress**

GPM: TREATMENT APPROACH

- **Interest in the patient's interpersonal experience**
- **Slow down cliches, assumptions, attributions, shortcuts**
- **Curiosity about the interpersonal context (and thoughts) preceding feelings and behaviors**

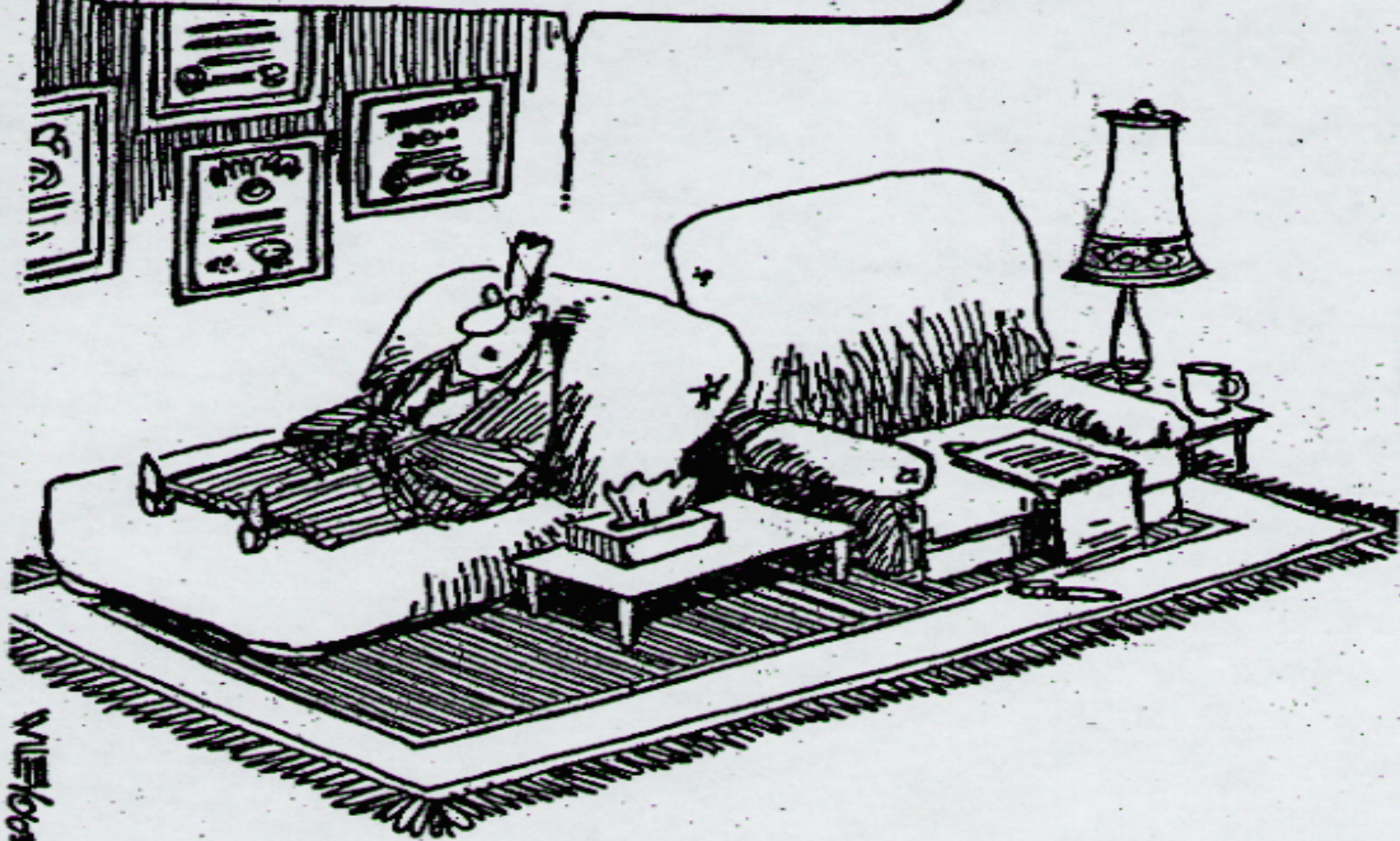
GPM' S & HYPERSENSITIVITY (cont)

- **explains need for psychotherapist activity**
- **lends itself to practical here and now issues**
- **explains the ambivalence of suicide attempts**
- **explains the role of hospitals, structure, and reliability (disorganization – containment)**
- **lends itself to caution, uncertainty, “not knowing”**

WHY TRADITIONAL PSA TECHNIQUES DON' T WORK:

- **neutrality -- encourages projections, abandonment**
- **interpretations of negative motivations -- experienced as blaming, invalidation**
- **passivity -- encourages fears of disinterest, neglect**

I DON'T FEEL LIKE WE'RE
MAKING MUCH PROGRESS
WITH MY ABANDONMENT
ISSUES, DOCTOR...



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Section 3: Overall Principles

GPM: THERAPEUTIC STANCE I

- **dyadic – a real relationship, selective self-disclosure**
- **corrective “container”**
 - **active, non-reactive**
 - **cautious, uncertain, thoughtful**
- **pragmatism – every patient is different; forego theory if it isn't working; if not now – wait**
- **realistically encouraging**

MYTHS ABOUT TREATMENT OF BPD

- **BPD patients resist treatment**
 - **most actively seek relief from subjective pain, treatment for their personality disorder requires psychoeducation by clinicians.**
- **BPD patients angrily attack their treaters**
 - **excessive anger and fearful wariness towards others, especially caregivers, are symptoms (i.e., instinctive transferences) of their disorder.**
- **BPD patients rarely get better**
 - **about 10% remit within 6 months, 25% by a year, and 50% by 2 years.**
- **Once remitted, relapses are unusual**
- **BPD patients get better only if given extended, intensive treatment by experts**
 - **such treatment is only required by a subsample. Most do well within intermittent treatment by well-meaning non-experts. Intense treatments can easily become regressive.**
- **Recurrent risk of suicide invariably burdens treaters and carries serious liability risks**
 - **excessive burden or fears of litigation are symptoms of inexperience and of treatments that are poorly structured.**
- **Recurrent crises require treaters to be available 24/7**
 - **such a requirement is rare and means a different level or type of care is needed**

SUPPORTIVE INTERVENTIONS FOR **BPD**

- **Validation (? trauma)**
- **Discerning self-disclosures**
(? countertransference)
- **Reassurance (? compliments)**

GPM: PRAGMATISM

- **“Non-specific factors are central – reliability, listening, concern**
- **Relational issues are central – attachment, trust positive dependency**
- **Situational changes can be essential**
- **“Interpretations” are best offered via questions or “normalizing”**
- **Mistaken interventions are inevitable, useful, and reversible**
- **Education is essential – even when seemingly ignored**

GPM: TREATMENT APPROACH: I

- **the inquisitive stance: your life is interesting, important, and unique**
- **external → internal; implicit → explicit (Gabbard)**
- **challenge silences, lateness, incivilities, superficiality**
- **actively address here-and-now interactions**
 - **not knowing (MBT)**
 - **interpretation (TFP)**
- **actively address negative “transference” – impatience, disdain; “Did I trouble/bother you?”**

PHASES OF THERAPY

- I. Building a contractual alliance: (1-3 mo)**
engagement - agreeing on goals
and roles
- II. Building a relational alliance (1-12 mo)**
- liking, trusting intentions
- III. Positive dependency (6-18 mo to 2.5-5 yr)**
- explicit, comfortable
- IV. Becoming non-borderline (recovery) (2-10 yr)**
- generalize learning

SEQUENCE OF EXPECTABLE CHANGES

<u>Target Area</u>	<u>Changes</u>	<u>Time</u>	<u>Relevant Interventions</u>
1. Subjective distress/ dysphoria	↓ anxiety & depression	1-6 wks	support, situational changes, ↑ self awareness
2. Behavior	↓ self-harm, rages & promiscuity	2-6 mos	↑ awareness of self & interpersonal triggers ↑ problem solving strategies
3. Interpersonal	↓ devaluation, ↑ assertiveness, & “+ dependency”	6-12 mos	↑ mentalization, ↑ stability of attachment
4. Social function	school/work/domestic responsibilities	6-18 mos	↓ fear, failure & abandonment, coaching

Adapted from Gunderson JG, Links P. Borderline Personality Disorder: A Clinical Guide. Second Edition. Washington, DC. American Psychiatric Press, Inc. 2008

PROCESSES OF CHANGE

- **“Think First” – cognitive learning**
- **“Get a Life” – social rehabilitation**
- **Corrective experiences – therapist as caretaker and role model**

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Section 4: Making the Diagnosis

“I cringe at the idea that I’m borderline. People assume they are malicious and manipulative. I don’t want that to be me.”

SOURCES OF STIGMA:

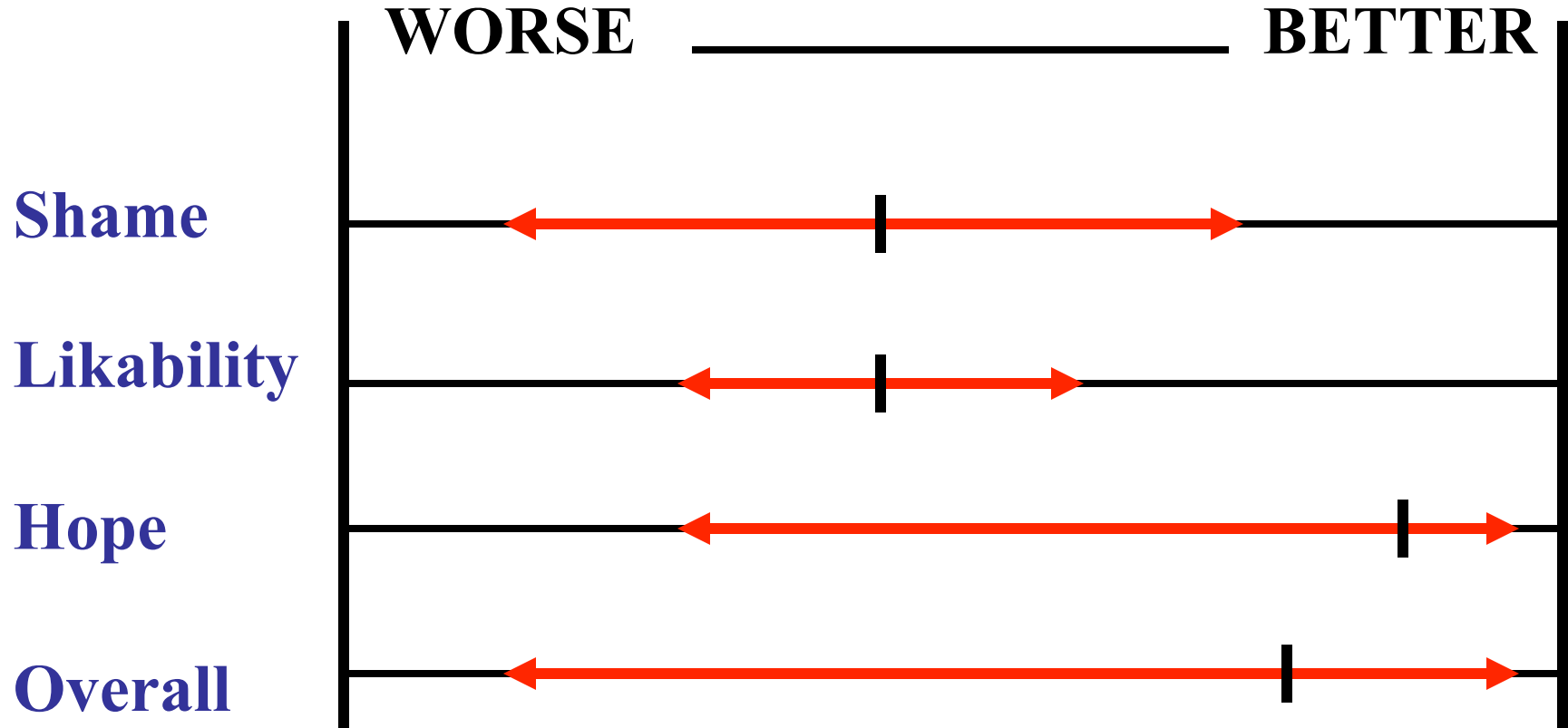
- **Reaction to anger, neediness (countertransference)**
- **The perception of willful treatment resistance (“help rejecting complainers”)**
- **Cross-sectional exposure (“frequent flyers”)**
- **Misinformation about heritability and prognosis**
- **Unrealistic expectations of competence**
- **PD’s don’t change, PD’s are character flaws**
- **BPDs self concept: “bad”, “evil” (Zanarini et al. 2001)**

BENEFITS OF DISCLOSING BPD DIAGNOSIS

- **Diminishes sense of uniqueness/alienation**
- **Establishes realistically hopeful expectations**
- **Decreases parent blaming and increases parent collaboration**
- **Increases patient alliance and compliance with treatment**
- **Prepares clinicians for their patient's hypersensitivity and to be aware of countertransference**

RESPONSES TO DIAGNOSIS OF BPD

(N = 30)



CRITERIA FOR THE DIAGNOSIS OF BORDERLINE PERSONALITY DISORDER

Five or more of the following criteria must be met:

Interpersonal hypersensitivity

Frantic efforts to avoid real or imagined abandonment

A pattern of unstable and intense interpersonal relationships, characterized by alternating between extremes of idealization and devaluation

Affective dysregulation

Affective instability because of a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety, usually lasting a few hours and only rarely more than a few days)

Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)

Chronic feelings of emptiness

Impulsivity

Impulsive behavior in at least two areas that are potentially self-damaging (e.g., spending money, sex, substance abuse, reckless driving, binge eating)

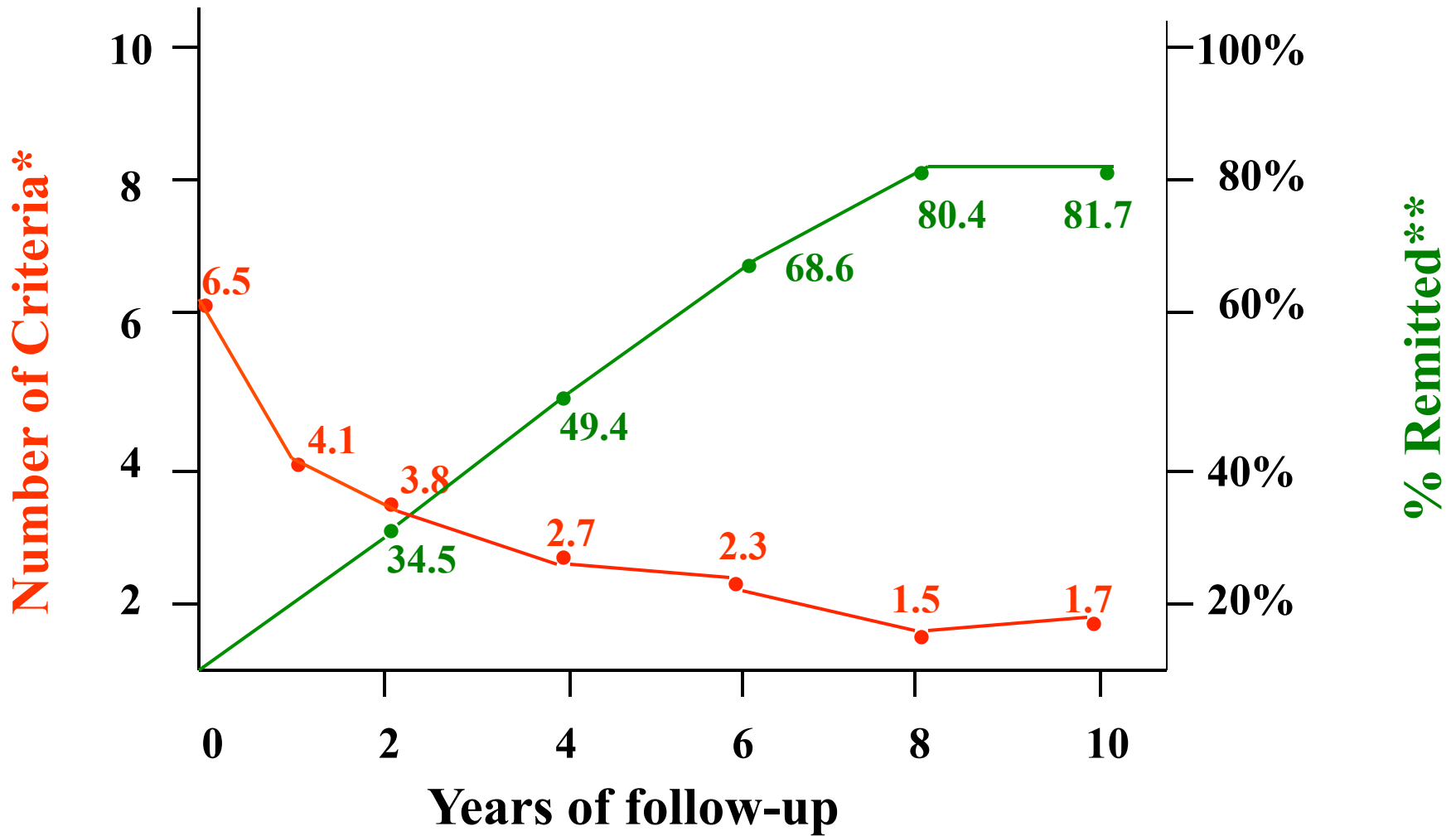
Recurrent suicidal behavior, gestures, or threats or self-mutilating behavior

Cognitive/self

Identity disturbance with markedly and persistently unstable self-image or sense of self

Dissociative symptoms and/or transient, stress-related paranoid ideation

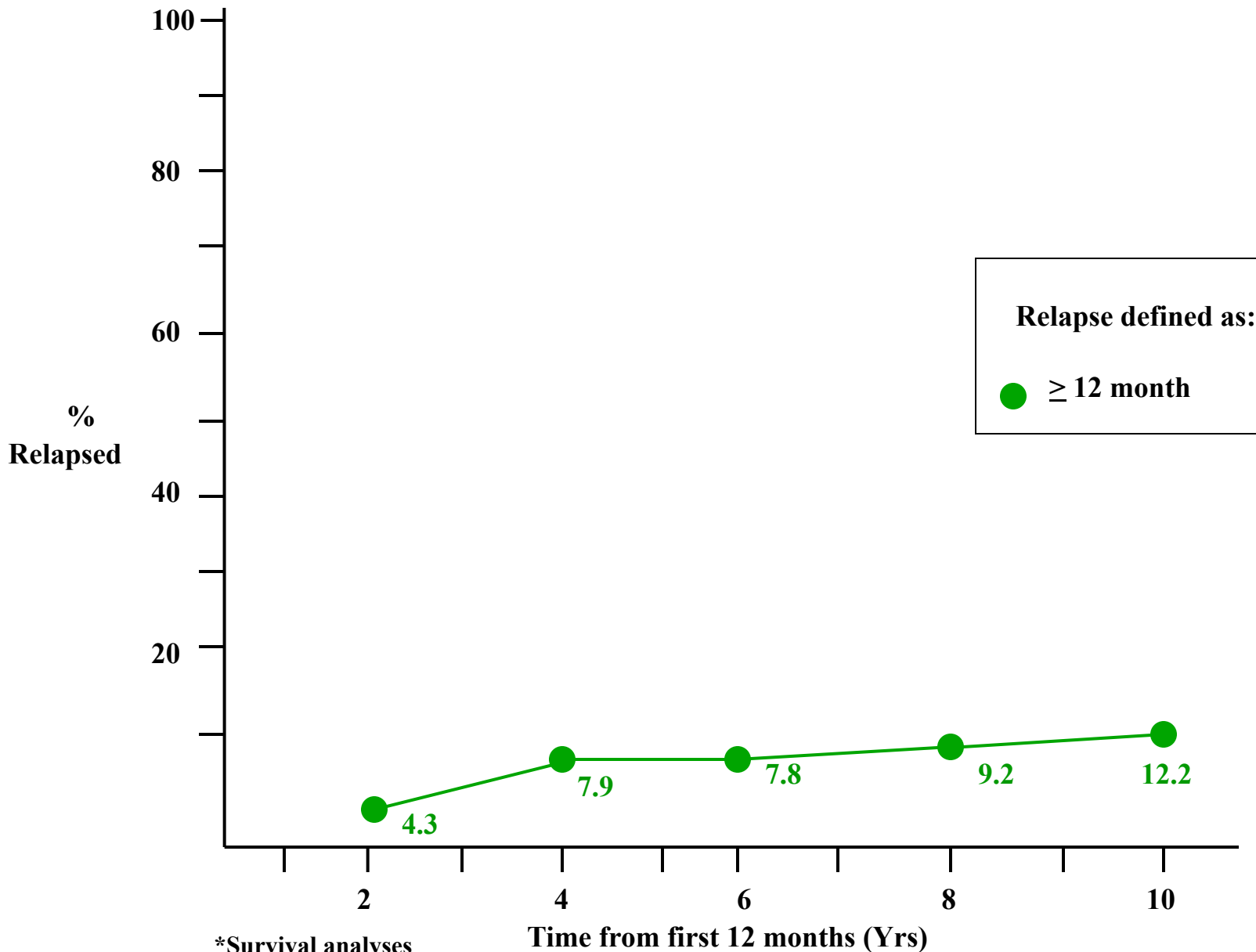
BPD's Longitudinal Course



*From the Collaborative Longitudinal Study of Personality Disorders (Gunderson et al. Arch Gen Psych 2011;68(8):827-837)

**From the McLean Study of Adult Development (Zanarini et al. AJP 2003; 160:274-283)

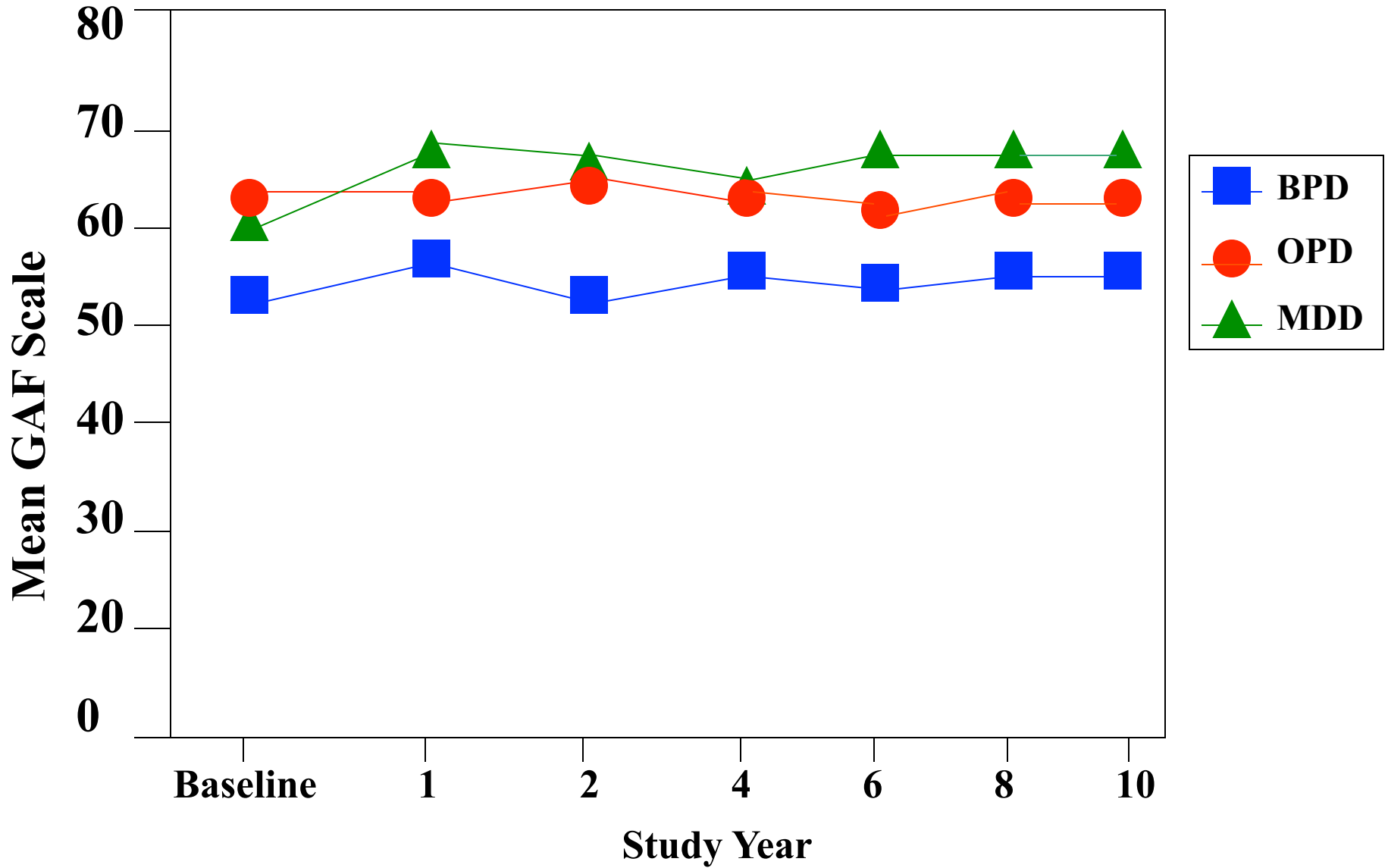
Ten Year Probability* of Relapse for BPD**



*Survival analyses

**DIPD Positive

MEAN GAF SCORES



HERITABILITY/FAMILIALITY

- **Among 92 identical and 129 fraternal twins**

Genes accounted for 69% of variance in etiology

Torgerson 2000

- **Two twin studies, 1 family study**

Single latent factor accounts for the co-occurrence of BPD's interpersonal, emotional, behavioral, and cognitive components

Gunderson, et al. ,2011; Kendler, et al., 2010; Distel, et al., 2009

PRINCIPLES OF PSYCHOEDUCATION FOR FAMILIES

- **Mental illness is a problem within the person, not a symptom of a problem family.**
- **Family support is needed for treatment of mental illness.**
- **Psychoeducation requires being informed about therapy, prognosis, and course.**
- **Psychoeducation can diminish harmful anger, criticism.**
- **Families often do not recognize the cost of the illness: family alienation and social isolation.**
- **“Bad” parents are uninformed or ill, not malevolent.**
- **Families are burdened; new management strategies can reduce this burden.**

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Section 5: Getting Started

GPM: ALLIANCE BUILDING

- **address cc: subjective distress & ADL' s (sleep, diet)**
 - **medications ?**
- **psychoeducation (hope)**
- **enlist patients' involvement**
 - **homework**
 - **email**
- **situational stressors (calls, conjoint meetings)**
- **availability: “Yes, but ...”**

GPM GOALS

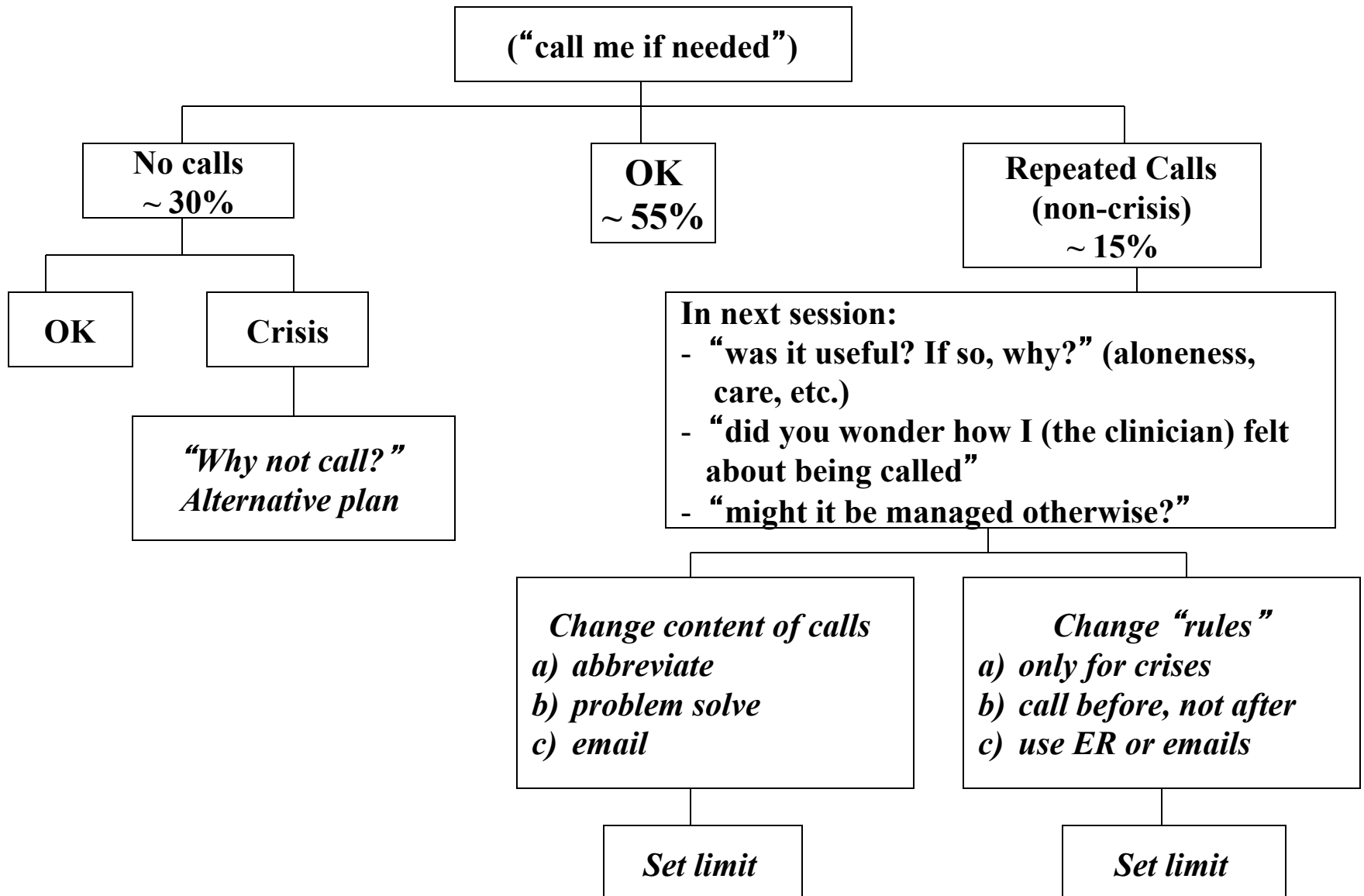
- **making them is alliance building**
- **making them is a goal, not required (“real world”)**
- **guided by feasibility (short term, simple)**
- **differences should not be addressed**
- **emphasizes “getting a life” (work > love)**



SUPRESS

"Yes, but what are your goals?"

Algorithm for Intersession Availability



COMMON PROBLEMS

- **Refusal to accept the framework**
- **Patient doesn't "connect"**
- **Treater dislikes patient**
- **Patient won't leave a
dysfunctional
relationship with prior treater**

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**Section 6: Managing Suicidality &
Self-Harm**

MANAGING SAFETY: SEVEN BASIC PRINCIPLES

- **Assess risk – differentiate nonlethal from true suicide intention**
- **Don't ignore or derogate – express concern**
- **Ask what the patient thinks could help – foster sense of “self-agency”**
- **Clarify precipitants (chain analysis) – seek interpersonal events**
- **Be clear about your limits; i.e., not being omniscient or omnipotent**
- **Always explore the meaning vis-à-vis the alliance with therapy/therapist**
- **Discuss with colleagues – consultation or supervision**

GUIDELINES TO MANAGING SAFETY: DURING CRISES

1. *Express concern* after the patient alerts you to suicidal or other safety issues.
2. *Allow patients to ventilate* - this will relieve tensions around suicidality.
3. *Avoid taking unilateral actions* to prevent potential suicidal behaviors when possible.
 - 3a) *Ask* patients to be explicit about wanting help.
 - 3b) *Ask* patients to be explicit about what help they hope you can offer.
 - 3c) *Assume*, unless told otherwise, that the patient can use community-based emergency services.
4. **Identify the stressor (rejection, step-down, etc.).**

GUIDELINES TO MANAGING SAFETY: AFTER CRISIS

- 1. *Follow up* by discussing all safety issues, including their effect on you, within the context of scheduled appointments.**
- 2. *Actively interpret* the non-specific reasons that can and did provide relief, i.e., the experience or perception of being cared for (“held”).**
- 3. *Identify* the unfeasibility of depending upon your availability.**
- 4. *Problem solve* about available alternatives.**
- 5. *Identify* the stressor (rejection, step-down, etc.).**

“GPM: What everyone needs to know”

**Section 7: Pharmacotherapy &
Comorbidity**

THE STATE OF KNOWLEDGE ABOUT PHARMACOTHERAPY OF BPD

- **About 30 RCTs have been conducted (antipsychotics (AP) > antidepressants (AD) > mood stabilizers (MS) > others), usually with small samples (avg N ~ 40), with variable outcome measures, and limited duration.**
- **No medication is uniformly or dramatically helpful.**
- **No drug has been licensed by the FDA as an effective treatment for BPD.**
- **Pharma-sponsored research has been limited by fears of violent or suicidal acts and associated liability.**
- **Polypharmacy is associated with multiple side-effects and no evidence supports augmentation.**
- **The number of medications taken is inversely related to improvement.**
- **Minimal attention has been given to medication effects on interpersonal relationships.**

ALLIANCE BUILDING FOR PSYCHOPHARMACOLOGISTS TREATING BPD

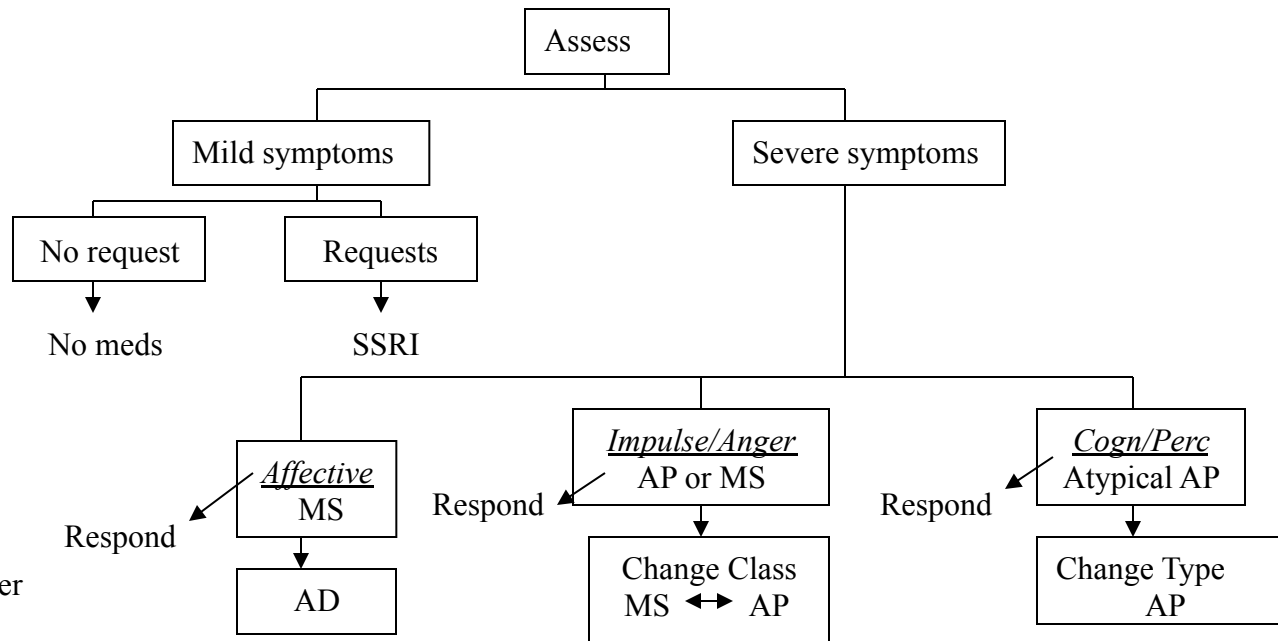
- 1) Temper high expectations**
- 2) Encourage the patient to read about whatever medications that you and s/he agree upon.**
- 3) Stress that effects are hard to evaluate and enlist the patient as an ally in this process. Indeed, encourage the patient to view this as a empirical process in which you learn together whether, and what, medications can help.**
- 4) Stress the necessity for responsible usage to evaluate effectiveness.**

STRATEGIES

- **Emphasize the need for collaboration**
- **Don't be proactive: prescribe new medications only if patient requests or you judge them to be "severely distressed" (complains about impaired attention, sleep, functions).**
- **If patient requests but is not severely distressed, be willing but cautious and use SSRI's (they can have modest benefits and may help establish an alliance).**
- **If patient is severely distressed but does not want medications, encourage but don't push.**
- **Establish policy that if patient is failing to respond to medication, you will taper it and only then begin a medication in another class (unless patient is severely distressed, then cross taper).**

ALGORITHM

- Assess: a) Patient's motivation, b) symptom severity and type: *anxiety/depression/affective instability, impulse/anger* and *cognitive/perceptual*, and c) current medications
- If patient is severely distressed or insistent proceed as follows:
 - *anxious/depressed/affectively unstable*, start with mood stabilizer (e.g., topiramate or lamotrigine) → move to antidepressants (e.g., SSRIs)
 - *impulsive/anger*, start with antipsychotics (e.g., aripiprazole or ziprasidone) → move to mood stabilizers
 - *cognitive/perceptual*, start with antipsychotics → move to mood stabilizers



MS = mood stabilizer
 AP = antipsychotic
 AD = antidepressant

At a Glance

	Anti- psychotics	Anti- depressants	Mood Stabilizers
Anger	++	+	+++
Depression	0	0	+
Anxiety	0	+	++
Impulsivity	+	0	+++
Cognitive- Perceptual	++	0	0
Functioning	+	0	++

Adapted from Ingenhoven 2010

BPD COMORBIDITY: WHICH DISORDER IS PRIMARY

	<u>Prev in BPD</u>	<u>BPD Prev in in Other Dis</u>	<u>BPD Primary?</u>	<u>Why</u>
DEPRESSION	50%	15%	Yes	Will remit if BPD does
BIPOLAR	15%	15%	No	Unable to use BPD therapy
- manic			Yes	Recurrence ↓ if BPD remits
- not manic			?	
- bipolar II				
PANIC	[?]	[?]	Yes	Will remit if BPD does, can precipitate BPD relapse
PTSD	30%	8%	No	Too vigilant to attach/be challenged
- early onset (complex)			Yes	BPD predisposes to onset, will remit if BPD does
- adult onset				
SUD	35%	10%	No	3-6 months sobriety makes BPD treatment feasible
ASPD	25%	25%	?	Is tx for 2° gain?
NPD	15%	25%	Yes	Will improve if BPD does
Eating Dis	20%	20%	No	Unable to use BPD treatment
- anorexia			?	Is physical health stable?
- bulimia				

“GPM: What everyone needs to know”

Section 8: Multimodel Treatments

RULES FOR PARTNERSHIP IN SPLIT TREATMENT

- **ESTABLISH CLEAR ROLES, ESPECIALLY WITH REGARD TO**
 - **Managing Crises**
 - **Taking phone calls from family members**
- **INSIST ON THE NEED (AND RIGHT) TO TALK TO EACH OTHER**
(Except for sensitive disclosures that don't involve safety or jeopardize the treatment)
- **EXAMINE, DON' T PROTECT OR AGREE WITH THE OTHER' S VILLIFICATION**
- **URGE THAT THE COMPLAINTS BE VOICED TO THE OTHER (this is a corrective experience)**

WHAT GROUPS ADD

- **social skills (listening, sharing, competing)**
- **self-disclosure (↓ shame, isolation)**
- **assertiveness (self-respect, self-care)**
- **self-other awareness (mentalizing)**

BPD GROUPS

- **Self-Assessment (situational adaptations, problem solving)**
- **DBT Skills Training (emotion regulation, impulse control, agency)**
- **MBT (self-other awareness, psychological-mindedness)**
- **Interpersonal (self disclosure, assertion, anger management)**

HIERARCHY OF FAMILY INTERVENTIONS

Psychoeducation – the initial form is about the disorder (Table II-2). This should be offered to all parents/spouses. The next form is about parenting [*A copy of basic **Family Guidelines** is available in Appendix C.*]

Counseling – review Family Guidelines, advise, problem solve [*Families usually welcome these sessions.*]

Support groups – Multiple Family Group, “Family Connections,” NEABPD/NAMI sponsored [*Helpful if available - clinics should develop.*]

Conjoint sessions (patient and parents) – useful for planning, problem solving issues such as (budget, sleep hygiene, treatment adherence, emergencies, vacations). Can be led by family counselor, primary clinician or both. [*Can be very helpful in sustaining the holding environment, decrease splitting.*]

Family therapy – destructive unless patient and parents can discuss conflicts without interrupting, having angry outbursts, or leaving. Parent blaming can be useful only if parents can accept with regrets whatever is true in the BPD patient’s allegations.

Family Guidelines

**Multiple Family Group Program
at
McLean Hospital**

**by
John Gunderson, M.D.
and
Cynthia Berkowitz, M.D.**

With support from the New England Personality Disorder Association

Guidelines for Families (A Sample)

- Recovery takes time. Go slow. Crises do resolve**
- Keep things “cool”. Enthusiasm and disagreements are normal. Tone them down.**
- Don’ t ignore threats of self-destructiveness. Express concern. Discuss with professionals.**
- Maintain family routines as much as possible. Don’ t forsake good times. Don’ t withdraw from friends.**
- Listen. Don’ t get defensive in the face of criticisms. However unfair, say little. Allow yourself to be hurt.**