A Generalist Model for Treating Borderline Personality Disorder

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Overview of BPD Treatment Landscape

1) Myths and historical lessons
2) Barriers to effective treatment
3) Need for a generalist approach to treatment and training

Current Context: Myths, Stigma, Inadequate Training

- Treatment of BPD is not done consistently or well
- Most clinicians do not like treating BPD patients
- Misinformation and hostility toward BPD diagnosis persist
- Disinterest by biological psychiatry
- Resistance to change – it is easier to do nothing
- There is a shortage of adequately trained BPD treaters

Myths about BPD Treatment

1. BPD patients resist treatment
   - Most actively seek relief from subjective pain
   - Treatment for personality disorder requires education by clinicians
   - Non-engagement and dropouts are likely when treatment is ineffective

2. BPD patients angrily attack their treaters
   - Excessive anger and fearful wariness toward others, especially caregivers, are symptoms of the disorder

3. BPD patients rarely get better
   - ~10% remit within 6 months, 25% by 1 year, 45% by 2 years (even without extended or stable treatment)

Why Traditional Psychoanalytic Techniques Do Not Work

- Neutrality encourages projections, sense of abandonment
- Interpretations of negative motivations experience of being blamed, invalidated
- Passivity encourages fears of disinterest, neglect

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Myths about BPD Treatment

4. Recurrent risk of suicide burdens treaters with excessive responsibility, constant intersession availability, and serious liability—These burdens are symptomatic of inexperience and poorly structured treatments

5. BPD patients only get better if given extended, intensive, specialized treatments by experts—Specialized treatment is only required by a subset of patients—Most patients do well with intermittent treatment by non-experts trained in generalist principles—Intense treatments can easily become regressive and counter-therapeutic

The Emergence of a Generalist Model

- Comparisons of specialist EBTs with generalist treatments show roughly equal outcomes—GPM vs DBT—MBT vs SFT—TFP vs DBT vs supportive therapy—Common factors underlie gains made in specialty EBTs—Public health need and clinicians’ training needs are best met by equipping non-specialists to deliver generalist treatment as “first-line” and refer refractory cases for specialist EBTs as “second-line”

Perils of BPD Treatment in Resource-Rich Environments

- “Alphabet soup” menu of specialist EBTs—Patient conflate “gold standard” with a specific EBT, or with more or lengthier treatment—Lack of coherent integration by clinicians trained in multiple modalities—No evidence-based guidelines for decisions to reduce, end, or switch between specific treatments...left up to clinical judgment

Good Psychiatric Management (GPM) and Its Place within BPD Treatment

1) Evidence for efficacy
2) Basic structure of treatment
3) Comparison to specialist treatments

RCT of GPM vs DBT

- Therapists had > 5 years experience
- GPM arm guided by Gunderson and Links' Borderline Personality Disorder: A Clinical Guide (2008), met for group supervision with Links
- Outcome = DBT: ↓DSH, hospitalizations, depression
- Outcome > DBT: BPD with increased comorbidity
  - ↓dropout for individuals with higher Axis I comorbidity in GPM compared to DBT

GPM Structure

- Once weekly individual appointments, if useful
- Case management
  - Focus on life outside treatment, not within
- Psychodynamic AND behavioral underpinnings
  - Psychodynamic: unrecognized motives and feelings, defenses related to interpersonal hypersensitivity
  - Behavioral: accountability, contingencies
- Begins with diagnosis and psychoeducation (medical model)
- Flexibly multimodal
  - Integrates psychopharmacology and medical oversight with groups, family therapy, other modalities

GPM vs DBT

- Single-blind RCT comparing 1 year of DBT (n = 90) to GPM (n = 90)
- Inclusion criteria:
  - Meet DSM-IV criteria for BPD
  - 18 to 60 years old
  - At least 2 episodes of suicidal or nonsuicidal self-injurious episodes in the past 5 years, at least 1 of which was in the 3 months preceding enrollment
- Exclusion criteria:
  - DSM-IV diagnosis of a psychotic disorder, bipolar I disorder, delirium, dementia, or mental retardation or a diagnosis of substance dependence in the preceding 30 days
  - Having a medical condition that precluded psychiatric medications
  - Living outside 40-mile radius of Toronto
  - Having any serious medical condition likely to require hospitalization within the next year
  - Having plans to leave the province in the next 2 years
- No difference between groups at baseline (mean # suicide attempts: DBT = 5, GPM = 4)

GPM vs DBT

- Assessments:
  - Structured Clinical Interview for DSM-IV Axis I Disorders–Patient Edition
  - International Personality Disorder Examination
  - Peabody Picture Vocabulary Test–Revised
- Outcome Measures:
  - Primary
    - Frequency and severity of suicidal and nonsuicidal self-injurious behavior
  - Secondary
    - Diagnostic criteria for BPD (Zanarini Rating Scale for BPD, ZAN-BPD)
    - Psychiatric symptoms (Symptom Checklists–90–Revised, SCL-90-R)
    - Anger (State-Trait Anger Expression, STAXI)
    - Depression (Beck Depression Inventory, BDI)
    - Interpersonal functioning (Inventory of Interpersonal Problems, IIP)
    - Health-related quality of life (EQ-5D thermometer)
    - Health care utilization (Treatment History Interview, THI)
  - Treatment retention

DBT GPM

Theoretical Basis
Learning theory, Zen philosophy, and dialectical philosophy. Pervasive emotion dysregulation is the primary deficit in BPD.

Psychodynamic approach drawn from Gunderson; emphasized the relational aspects and early attachment relationships. Disrupted attachment relationships related to emotion dysregulation as a primary deficit.

Basis

Treatment Structure
Multimodal: Individual session (1 hour weekly); skills group (2 hours weekly); Consultation team for therapists (2 hours weekly); TOTAL 9 hours

One mode: Individual sessions (1 hour weekly) including medication management based on structured drug algorithm; Therapist supervision meeting mandated (90 minutes weekly); TOTAL 2.5 hours

Hierarchy of targets: suicidal > treatment-interfering > and quality-of-life-interfering behaviors

No hierarchy of targets

Explicit focus on self-harm and suicidal behaviors

Focus is suspended away from self-harm and suicidal behaviors

Primary Strategies
Psychoeducation about BPD
Helping relationship
Here-and-now focus
Emotion focus
Dialectical strategies
Irreverent and reciprocal communication style
Formal skills training
Behavioral strategies: exposure, contingency, management, diary card, behavioral analysis

Secondary Strategies
Psychoeducation about BPD
Helping relationship
Here-and-now focus
Validation and empathy
Emotion focus
Active attention to signs of negative transference

Crisis Management Protocols
Bias toward managing crises on an outpatient basis; phone coaching to assist in managing crises

Hospitalization seen as helpful if indicated

Medications
Patients encouraged to rely on skills over pills where appropriate (e.g., anxiolytics). Tapering from medications was a treatment goal.

Physiopsychiatric intervention was uncontrolled

Patients were encouraged to use medications concurrently. Two medication algorithms, one related to mood lability and one related to impulsivity-aggressiveness, were prioritized as symptom targets. Medication intervention was delivered according to the predominant symptom pattern.


GPM vs DBT


GPM vs DBT

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>P-value</th>
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<tbody>
<tr>
<td></td>
<td>DBT (N=95)</td>
<td>GPM (N=95)</td>
</tr>
<tr>
<td>Health-related quality of life (SD-50)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline</td>
<td>37.69</td>
<td>55.29</td>
</tr>
<tr>
<td>12 months</td>
<td>33.64</td>
<td>58.41</td>
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<tr>
<td>Symptom distress (SCL-90-R)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline</td>
<td>1.91</td>
<td>1.94</td>
</tr>
<tr>
<td>12 months</td>
<td>1.35</td>
<td>1.36</td>
</tr>
<tr>
<td>Interpersonal functioning (IP total)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline</td>
<td>116.58</td>
<td>120.95</td>
</tr>
<tr>
<td>12 months</td>
<td>103.24</td>
<td>101.58</td>
</tr>
</tbody>
</table>


GPM vs DBT: Key Results

• Both GPM and DBT → significant improvements in:
  – Frequency and severity of suicidal and nonsuicidal self-injurious episodes
  – Most secondary clinical outcomes (Sx severity, depression, IP functioning)
• No differences in outcomes between specialized and generalist approaches after 1 year of treatment
  – DBT is NOT significantly better in diminishing self-destructive behaviors
  – GPM is NOT significantly better in improving interpersonal functioning

GPM vs DBT: 2-year Follow-up Study

• Of the original 180 participants: 131 (73%), 128 (71%), 118 (66%), and 110 (61%) completed assessments at 18, 24, 30, and 36 months, respectively
• There were no group differences in follow-up assessments, and no differences in the characteristics of participants, except that the prevalence of cluster C personality disorders was higher in participants that completed ≥ 1 follow-up than those lost to follow-up

Symptomatic vs Functional Gains

• 2/3 of participants remitted, but disability and unemployment remained high
  – 39% on disability
  – 53% unemployed
• Work was not emphasized in either DBT or GPM

GPM vs DBT: Dropout Comparison

• Generally, BPD associated with high rates of dropout, poorer outcomes, clinician demoralization
• High dropout rate (38%), but no between-group differences
• Factors that predicted dropout:
  – ↑Levels of anger, Axis I comorbidity, # lifetime suicide attempts
  – Poorer therapeutic alliance (patient-reported)
• ↓Dropout rates in those with ↑Axis I comorbidity assigned to GPM (as compared to DBT)

General → “Good” Psychiatric Management

### GPM’s Relation to Other EBTs

- What BPD patients should expect their treaters to know
- Good enough for most BPD patients
- Those who fail → DBT, MBT, TFP, etc

### GPM’s Distinct Structural Features

- Diagnostic disclosure – essential first step
- Case management – rather than psychotherapy
- Psychoeducation – genetics, course/prognosis, importance of functioning outside of treatment
- Flexibly multimodal AND “medicalized” – PRN use of medications, comorbidity management, group AND family interventions “only if useful”
- Progress – determines duration and intensity; benchmarks are monitored
- Interpersonal hypersensitivity – explains emotional and behavioral shifts

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### GPM Principles

#### Getting Started: Diagnostic Disclosure and Psychoeducation

- GPM begins with:
  - 1) Making, disclosing, and explaining the diagnosis
  - 2) Providing psychoeducation about course, prognosis, standard treatment trajectories
- Highlight the interpersonal coherence of diverse symptoms and presentations
- Instills hope, motivation for treatment
- Sparks self-reflection
- Builds toward a shared formulation

### Interpersonal Hypersensitivity as BPD’s Core

- Affective, impulsive, interpersonal, and cognitive elements co-occur, united by a latent core factor
- Unifying latent core is genetic disposition with ~ 55% heritability (> MDD, < SCZ)
- Interpersonal features are the most discriminating
- Interpersonal events predict remissions/relapses, SIB, dissociation, suicide
- BPD has ↑ cortisol and HPA (stress) reactivity and neurohormone (social psychological) deficits
- Childhood disorganized attachments, separation problems, and hypersensitivity predict adult BPD

### Start at the Beginning...

- GPM begins with:
  - 1) Making, disclosing, and explaining the diagnosis
  - Highlight the interpersonal coherence of diverse symptoms and presentations
  - 2) Providing psychoeducation about course, prognosis, standard treatment trajectories
- Instills hope, motivation for treatment
- Sparks self-reflection
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### Neuropeptide Abnormalities Associated with BPD’s Interpersonal Hypersensitivity

- Low opioids – ↑ sensitivity to rejection, abandonment
- Low oxytocin – ↑ social sensitivity, distrust, antagonism
- High vasopressin – ↑ anger within close relations

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*HPA = hypothalamic-pituitary-adrenal; MDD = major depressive disorder; SCZ = schizophrenia; SIB = self-injurious behavior.*


It’s (Mostly) Not about You


Interpersonal Hypersensitivity in Clinical Context

- Sensitivity/reactivity to feeling “held” vs disconnected predicts and explains the clinical phenomenology
- Emotional, behavioral, cognitive/perceptual symptom domains emerge in relation to interpersonal stress

BPD’s Interpersonal Coherence

- Compliant: idealizing, dependent, rejection-sensitive
- Difficult: defensive, Self-injurious, angry, anxious
- Help-seeking: help-seeking
- Withdrawn by the other: breakup, walking out
- Ambivalent: dissolution, personal impulsive, help-rejecting
- Dissociation, paranoid
- Impulsive, help-rejecting
- Holding environment: hospital, jail, rescuer
- Aloneness: suicide, anhedonic

Interpersonal Hypersensitivity in Clinical Context

- Sensitivity/reactivity to feeling “held” vs disconnected predicts and explains the clinical phenomenology
- Emotional, behavioral, cognitive/perceptual symptom domains emerge in relation to interpersonal stress
- Psychodynamic “meanings” to look for:
  - Unacceptable anger or passivity → “I’m bad”
  - Projected anger → “I’m a victim, no one cares”
  - Attachment → dependency, exploitation, inseparability
- Behavioral progress to look for:
  - Access to treatment relationships contingent on ability to productively use them, demonstration of progress
  - Value of insight is assessed using markers of behavioral change

Video Clip

- www.appi.org/gunderson
- Video #2: Diagnostic disclosure and psychoeducation

Illustrates:
- Collaborative approach to making the diagnosis through reviewing each criterion in depth
- Discussion of BPD’s etiology (both genetic and environmental components)
- Reference to BPD’s interpersonal phenomenology/coherence, which will help guide future treatment and interpretation of symptoms
Importance of Psychoeducation

Patient comments on the BPD diagnosis:
• “Is BPD just maladaptive habits modeled on dysfunctional adults?”
• “I know I have a disorder. It’s not that I am BPD, I have BPD.”
• “Getting the diagnosis explains so much. I couldn’t make sense of my experience. I’m not just crazy.”
• “Isn’t bipolar II when you’re borderline and then you’re not, and then you get medications?”
• “I cringe at the idea that I’m borderline. People assume they are malicious and manipulative. I don’t want that to be me.”
• “I’m filled with poison. It’s not my fault I’m poisonous.”

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 adherence with treatment
• Prepares clinicians for patients’ hypersensitivity and to be aware of countertransference
• Sets the stage for organizing the treatment primarily around BPD, and handling (most) comorbidities as secondary

Longitudinal Course and Prognosis

<table>
<thead>
<tr>
<th>Number of Criteria</th>
<th>Remitted (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td>1</td>
<td>80%</td>
</tr>
<tr>
<td>2</td>
<td>60%</td>
</tr>
<tr>
<td>3</td>
<td>40%</td>
</tr>
<tr>
<td>4</td>
<td>20%</td>
</tr>
<tr>
<td>5</td>
<td>10%</td>
</tr>
<tr>
<td>6</td>
<td>5%</td>
</tr>
<tr>
<td>7</td>
<td>1%</td>
</tr>
<tr>
<td>8</td>
<td>0%</td>
</tr>
</tbody>
</table>

Relapse defined as:
> 12 month

Time from First 12 Months (Years)

10-year Probability of Relapse

10-year Probability of Relapse: 4.3, 7.9, 7.8, 9.2, 12.2

Mean GAF Scores

GPM Principles

Basic Therapeutic Stance
### Core Principles of GPM Stance

1. **Psychoeducation**
   - Discuss diagnosis, expected course, treatment barriers
   - Relate shifting Sx and presentations to interpersonal coherence
   - Use what you know to generate shared reflection on problems

2. **Be active, not reactive**
   - Actively respond with support, interest, curiosity
   - Selectively validate
   - Challenge passivity, silences, avoidance, diversions, deflections
   - Be a thoughtful, cautious “container” for angry, fearful projections
   - Avoid unnecessary action (medication changes, hospitalization, referrals)

3. **The relationship is real (dyadic) and professional**
   - Use selective disclosure:
     - How patient affects you: “you scared me”
     - How you can relate: “that would make me angry”
   - Apologize for your mistakes

4. **Expect change**
   - Set expectation that ongoing Tx will be contingent on progress and effort
   - Expect gradual improvement
   - Predict that progress will activate anxiety and Sx associated with feeling less supported/held
   - Evaluate standard benchmarks (question whether Tx is working when not met)

### Getting Started

“I’d be glad to meet with you weekly, but I’m reluctant to meet more often until we see whether I can be useful. We’ll both know that by observing whether you feel better and whether these problems in your behavior (eg, anger, self-harm) and relationships (eg, distrust, control) are getting better.”

### Sequence of Expected Progress

<table>
<thead>
<tr>
<th>Domain</th>
<th>Duration</th>
<th>Sx𝛌&lt;sub&gt;increase&lt;/sub&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subjective distress</td>
<td>Anxiety, depression, overall subjective distress (1–3 weeks)</td>
<td></td>
</tr>
<tr>
<td>Behavior</td>
<td>Self-harm, rages, promiscuity (6–12 months)</td>
<td></td>
</tr>
<tr>
<td>Relationships</td>
<td>Derangement, disarray, positive dependency (6–12 months)</td>
<td></td>
</tr>
<tr>
<td>Social function</td>
<td>School, work, domestic responsibilities (6–12 months)</td>
<td></td>
</tr>
</tbody>
</table>
GPM “Red Flags” – When to Question Whether Treatment is Failing

<table>
<thead>
<tr>
<th>Time in Treatment</th>
<th>Observation</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 weeks</td>
<td>Attendance poor&lt;br&gt;Subjective distress not improved&lt;br&gt;You do not like the patient</td>
</tr>
<tr>
<td>3 months</td>
<td>Patient consistently disparages the treatment&lt;br&gt;Self-endangering events or ADLs worsen&lt;br&gt;Your empathy or understanding has not improved</td>
</tr>
<tr>
<td>6 months</td>
<td>Level of self-endangering behaviors persists&lt;br&gt;Patient forgets or does not use lessons from prior sessions&lt;br&gt;Patient fails to attain/resume part-time vocational role&lt;br&gt;Patient fails to recognize significance of challenging IP events (rejection, separation, withdrawal of support)</td>
</tr>
</tbody>
</table>

ADLs = activities of daily living.


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GPM “Red Flags” – When to Question Whether Treatment is Failing

<table>
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<tr>
<th>Time in Treatment</th>
<th>Observation</th>
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</thead>
<tbody>
<tr>
<td>Year 2</td>
<td>Acute desperation has not progressed to more stable loneliness&lt;br&gt;Mistrust has not progressed to positive/healthy dependency</td>
</tr>
<tr>
<td>Year 3</td>
<td>Externalizing rage persists (in place of “owning anger”)&lt;br&gt;Intense/exclusive relationships or isolation persist (inability to make stable friendships)&lt;br&gt;No progress toward long-term vocational goals&lt;br&gt;Intolerance of competition</td>
</tr>
<tr>
<td>Years 4–5</td>
<td>Depression has not evolved to sadness, dissatisfaction&lt;br&gt;Relationship with treaters not yet expendable, warm</td>
</tr>
</tbody>
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Core Principles of GPM Stance

5. Foster accountability
- Enlist active collaboration, agency in using Tx to improve one's own life
- Hold patients accountable for:
  - What they say
  - Following through with past promises
  - Remembering past discussions
  - Completing homework
- Work to understand what got in the way

6. Focus on “getting a life” outside of treatment
- Inform that vocational and social structures buffer IP hypersensitivities
- Work > love
- Actively inquire about:
  - Building relationships outside Tx settings
  - Vocational effo (recovery job → career orientation, enduring social role)
- Do not overly focus on:
  - Sx presented in the sick role
  - The Tx relationship

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GPM’s Overarching Focus is on “Getting a Life”

- Core principle → The patient must improve outside of the treatment to justify ongoing treatment
- Importance of vocational focus is shown in epidemiological studies and clinical trials:
  - Zanarini MC et al – 16-year prospective f/u → substantial reduction in Sx severity, but enduring social and vocational dysfunction
  - McMain et al – 2-year f/u → marked functional impairment despite well-organized treatment
  - Bateman/Fonagy – 8-year f/u → ongoing functional impairment
- Treatment is only secondarily guided by changes in specific Sx or Bx

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Core Principles of GPM Stance

7. Be flexible, pragmatic, eclectic
- Add/subtract adjunctive modalities while evaluating effects
- Change tactics, interventions, stance based on:
  - Patient’s state of mind and concerns
  - Quality of Tx relationship
  - What works
Video Clip

- [www.appi.org/gunderson](http://www.appi.org/gunderson)
- Video #6: Anger management ("leaning in")

Illustrates:
- Active/non-reactive ("I don’t know why you are angry")
- Support/validation ("I see where you are coming from")
- Dyadic, real relationship ("I’m sorry")
- Outside focus ("It’s still important for you to get a job")
- Embrace mistakes (inevitable, useful, and reversible)

GPM Principles

Managing Self-Harm, Suicidality, Liability, Risk

BPD’s “Behavioral Specialty”: Suicidality and Self-Harm

- Risk of suicide is significant
  - Estimates vary from 3% to 10%
  - Highest within young females (~33% of youth suicide)
  - Average number of suicide attempts is 3
  - Suicide occurs once per 23 attempts
- About 75% self-harm
  - Among these, 90% do so repeatedly
  - Self-harm increases the risk of suicide 15 to 30x
- Suicidal acts are typically ambivalent:
  - "If rescued, I want to live. If not, I prefer to die.”

Managing Safety: Basic Principles

1. Assess risk
2. Express concern
3. Ask what the patient thinks could help
4. Clarify precipitants (chain analysis)
5. Be clear about your limits
6. Explore the meaning vis-à-vis the therapy
7. Develop safety plan
8. Discuss with colleagues

Algorithm for Selecting Level of Care

Levels of Care:
- OP: outpatient clinic/office practice
- IOP: intensive outpatient (>3 hours/week/partial hospital >10 hours/week)
- Residential: structured living environments (e.g., halfway house)
- Hospital

Effective Uses of Hospital

- Safe asylum ("time-out")
- Evaluate treatment and consider changes if failing
- Assess and address situational stressors
  - Family conflict, work, transitions across levels of support
- Develop step down/aftercare plans
Managing Safety: During a Crisis

1. Express concern when patient alerts you to suicidal, self-injurious, or other unsafe behavior
2. Allow ventilation to relieve tensions around suicidality
3. Avoid taking unilateral action to prevent suicide (when possible)
   - Ask patients to explicitly ask for help
   - Ask patients to specify what help they hope you will provide
   - Assume, unless told otherwise, they can use community-based emergency services
4. Identify the acute stressor
   - Search for interpersonal elements (rejection, breakup, loss of support, step down from higher level of care)

Managing Safety: After a Crisis

1. Follow-up by thoroughly discussing what happened
   - Include the effect on you
   - Keep discussion within the context of scheduled appointments
2. Discuss the interpersonal stressors
   - Aloneness, rejection, step down
3. Actively interpret the nonspecific reasons that can and did provide relief
   - ie, the experience or perception of being cared for
4. Identify the unfeasibility of depending on your availability to be safe
5. Problem-solve to find available alternatives

Medical Liability

- The risk of liability is higher than for most psychiatric patients, but remains low (< 1%) and becomes negligible amongst experienced clinicians
- Liability largely (only?) derives from countertransference enactments – excessive availability, punitive hostility, personal involvement, illusions of omniscience or omnipotence
- Liability is greatly diminished by discussing your patients with colleagues, by use of consultants, or by having split treatments

GPM Principles

Psychopharmacology

State of Knowledge about Pharmacotherapy for BPD

- ~30 RCTs completed
  - APs > ADs > MS > others
  - Usually small samples (average N ~40), variable outcome measures, limited duration
  - No medication is uniformly or dramatically helpful
  - No medication is currently licensed by the FDA for BPD
    - Pharma-sponsored research has been limited by fears of violent/suicidal acts and associated liability
    - Polypharmacy is common (~40% take ≥3 meds) and associated with adverse effects and poorly structured “split” treatments
  - No evidence supports augmentation
  - # of medications inversely related to improvement
  - Zero data about med effects on IP relationships (BPD’s core)

Alliance-Building Around Medications

- Temper high expectations
- Encourage patients to read about agreed-upon medications
- Stress that effects are hard to evaluate, and enlist collaboration in a shared empirical process in which you learn together over time which medications, if any, helps
- Stress need for responsible use in order to evaluate effectiveness
Psychopharmacology Stance

“Id like you to try this medication knowing that whether it will help is not certain. You will need to help me assess its effectiveness. It will be helpful for you to read as much as you can about the medication and to monitor whether you see improvement in the symptoms that it’s intended to target. Will you do this?”

General Psychopharmacology Strategies

- Emphasize the need for collaboration
- Don’t prescribe proactively – wait until patient requests of you judge them to be “severely distressed”
  - If patient requests but is not severely distressed, be willing but cautious, and use SSRIs (modest benefits, may help establish alliance)
  - If patient is severely distressed but does not want medications, encourage but do not push
- Establish policy of tapering any medications to which patient does not respond before starting a medication from another class (may cross-taper if patient is severely distressed)

Psychopharmacology Algorithm

- If patient severely distressed or insistent, proceed with Sx-targeted approach:
  - Anxious/depressed/affectively unstable → MS, then AD
  - Impulsive/angry → AP, then MS
  - Cognitive/perceptual Sx → AP, then MS

Symptom Targets by Medication Types

<table>
<thead>
<tr>
<th></th>
<th>Mood instability</th>
<th>Depression</th>
<th>Anxiety</th>
<th>Anger</th>
<th>Impulsivity</th>
<th>Cognitive/ perceptual</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SSRIs</strong></td>
<td>?</td>
<td>+</td>
<td>?</td>
<td>?</td>
<td>+</td>
<td>-</td>
</tr>
<tr>
<td><strong>TCAs</strong></td>
<td>-</td>
<td>-</td>
<td>+</td>
<td>?</td>
<td>-</td>
<td>-</td>
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<tr>
<td><strong>Mood stabilizers</strong></td>
<td>+</td>
<td>?/+</td>
<td>?</td>
<td>++</td>
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<td><strong>Antipsychotics</strong></td>
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<td>?</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>++</td>
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<tr>
<td><strong>Anxiolytics</strong></td>
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<td>-</td>
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<td>-</td>
<td>?</td>
<td>?</td>
</tr>
</tbody>
</table>

++ = helpful; + = modestly helpful; ? = uncertain; - = negative; TCA = tricyclic antidepressant.

Clinical Pearls

- Benzodiazepines
  - Relatively contraindicated due to risks of:
    - Dependence, disinhibition, circumventing psychological exposure
  - Mood stabilizers
    - Broadest effectiveness (anger/impulsivity > depression, affective instability)
  - Antipsychotics
    - 2nd broadest effectiveness
    - Side effect profile warrants focused, time-limited trials

GPM Principles

Managing Comorbidities
Interactions between BPD and Major Comorbidities

<table>
<thead>
<tr>
<th>Effect</th>
<th>Co-Occurring Axis I Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>↓ BPD Course</td>
<td>MDD Bipolar Anxiety D/O PTSD SUD ED</td>
</tr>
<tr>
<td>MAYBE</td>
<td>NO NO YES YES NO</td>
</tr>
<tr>
<td>↓ Axis I Course</td>
<td>YES NO YES YES NO</td>
</tr>
</tbody>
</table>

ED = eating disorder; PTSD = posttraumatic stress disorder; SUD = substance use disorder.

Effect Co-Occurring Axis I Disorder

BPD stress-sensitive, frequently anxious
- Psychoeducation about interpersonal stressors, good prognosis can help anxiety management
- Medication secondary but sometimes helpful
  - Mood stabilizers likely primary, can try SSRIs
  - PRN anxiolytics are hazardous – only attempt if integrated with self-assessment/tracking techniques (eg. diary card)
  - Benzodiazepines should have minimal role

<table>
<thead>
<tr>
<th>Comorbid Anxiety</th>
</tr>
</thead>
</table>

Comorbid Substance Use

- **Dependency** → require at a minimum a 30- to 60-day sober period, prefer 6 months
- **Abuse** → integrate sobriety supports (12-step meetings, sponsor, monitoring/toxicology screens) into BPD-targeted treatment

Which Disorder is Primary?

<table>
<thead>
<tr>
<th>Disorder</th>
<th>BPD Primary?</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>Yes</td>
<td>Will remit if BPD does</td>
</tr>
<tr>
<td>Bipolar disorder</td>
<td>No</td>
<td>Unable to use BPD therapy</td>
</tr>
<tr>
<td>Anxiety D/O</td>
<td>Yes</td>
<td>Unnecessary; BPD needs mental health treatment</td>
</tr>
<tr>
<td>PTSD</td>
<td>Yes</td>
<td>Will remit if BPD does</td>
</tr>
<tr>
<td>Substance use disorder</td>
<td>No</td>
<td>2–6 months sobriety makes BPD Tx feasible</td>
</tr>
<tr>
<td>Antisocial PD</td>
<td>?</td>
<td>In them 2° gains?</td>
</tr>
<tr>
<td>Narcissistic PD</td>
<td>Yes</td>
<td>Will improve if BPD does</td>
</tr>
<tr>
<td>Eating disorder</td>
<td>?</td>
<td>Unable to use BPD treatment in physical health stability</td>
</tr>
</tbody>
</table>

Conclusions

BPD and GPM’s Place within Psychiatry

Good Psychiatric Management for BPD, In a Nutshell

- A treatment for BPD that is:
  - Evidence-based
  - Non-specialist
  - Commonsensical
  - Flexibly multimodal
  - Distillation of strategies independently found to be effective by clinicians all over
GPM’s Distinctive Features

- Medicalize the diagnosis
  - Disclosure, psychoeducation, integrate medication management
- Case management model > psychotherapy
  - Goal is “getting a life” outside of treatment
- Frequency and duration contingent on progress/change
  - Monitor benchmarks of progress openly from the start
- Emphasize work > love

GPM and Meeting the Public Health Demand

- BPD patients should be able to assume that the professionals who treat them have been trained to do so
- Informed generalist approaches (GPM) can be just as effective as specialist treatments for BPD
- GPM requires less training, clinical face time, and specialization
- GPM may be more effective at addressing comorbidities
- GPM training effectively changes clinician attitudes and feelings of competence
- All treatment approaches to BPD may be improved by emphasizing work and real-world functioning

Effects of GPM Workshops on Clinician Attitudes

- N = 297
- ↓ inclination to avoid/dislike BPD patients
- ↑ optimism, sense of competence and being able to make a difference while treating BPD patients
- More experienced clinicians say:
  - “It validates what I’ve learned the hard way”

Why Choose to Work with BPD?

- Addresses a major public health problem
- Pride in skills
  - “If you can treat borderline patients, you can treat anyone”
- Personal growth
  - The work draws deeply from our own personhood
- Satisfaction of having a highly personal, deeply appreciated, life-changing role with someone

THE END