Cutting Edge Treatments for Borderline Personality Disorder:

A Symposium with Dr. Marsha Linehan and Columbia University Faculty

Saturday, March 28, 2009

Current Medication Strategies for Treating Borderline Personality Disorder

Dave A. Kahn, M.D.

Medication for Mood Regulation in Borderline Personality Disorder

Topics covered today

1. What are we actually treating?
2. What does the evidence show?
3. Practical recommendations

What are we treating?

The Axis II personality disorder itself,

or a comorbid Axis I disorder?

It can be hard to tell.

Axis II: DSM IV overview

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:

- cognition (perception and interpretation of self, others and events)
- affect (the range, intensity, lability, and appropriateness of emotional response)
- impulse control (behavior destructive to self or others)

Change in Diagnostic Criteria for BPD: Relationship to mood

- DSM III-R: "marked shifts from baseline mood to depression, irritability, or anxiety, usually lasting a few hours and only rarely more than a few days"
- DSM IV: "affective instability due to 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).

What is "comorbidity" ?

Four models, no best answer:

- BPD is primary; depression are secondary to consequent interpersonal disruptions
- BPD is a form of mood disorder
  - Neurobiological overlap, family history, atypical depressive course of reactivity
- Disorders are independent
- Overlapping risk factors; each predisposes to the other through psychosocial sequelae

Lifetime Comorbidity

- Mood disorders: 96.9% of pts with BPD have one (Koenigsberg, 2002)
  - >85% major depression or dysthymia lifetime, >>33% prevalance
  - 29% bipolar II: Often differentiates BPD from other PD's
  - 12% cyclothymia
  - Bipolar I: Usually excluded from study populations of borderline personality; but about 1/3 patients with bipolar disorder also have borderline personality disorder
- Anxiety disorders – 90% of pts with BPD have one
  - Panic, social phobia, PTSD most common
- Eating disorders
- Somatoform disorders
- Dissociative disorders
- Substance abuse – 62%
- *Links to ADHD and learning disorders have not been well studied*

Zanarini et al, 2004; inpatients

Comorbidity is higher in BPD than other PDs

%	Borderline, N = 290	Other PD, N = 72
Any mood dis*	97	80
Major dep.	87	76
Dysthymia	44	29
Substance Ab.	62	46
Any Anxiety*	89	40
Panic	45	20
Social Phob	50	22
PTSD	58	25
Eating Dis.	54	20

* Significant

Comorbidity 6 years later: Axis I Improves more often if BPD remits*

Zanarini et al 2004

Status of BPD / Also has	Future Remitted Baseline %	Remitted At 6 year f/u	Future Unremitted Baseline	Unremitted At 6 year f/u
Mood disorder	97	70	96	92
Substance Use disorder	61	12	63	41
PTSD	53	23	71	46
Other anxiety disorder	88	50	81	60
Eating disorder	55	26	52	58

*Declines in remitters significantly greater in all except eating disorders

Col 2+4 % mod Did not remit

Impact of comorbidity: BPD takes much longer to remit if Axis I disorder does not remit

If this disorder persisted...	*It took proportionately this much longer for BPD to remit*	*p*
Mood	1.97	<.001
Substance	4.01	<.001
PTSD	2.12	<.001
Other anxiety	1.93	<.001
Eating	1.52	.012

Zanarini et al 2004

Overlap with Major Depression: Symptoms in BPD

- BPD shows greater morning/evening variability, more random moods (Cowdry 1992)
- More emptiness, worthlessness

Overlap with Bipolar II

- Shares with BDP:
  - increased impulsivity
  - lability
  - irritability
- Differences:
  - Not always clear in reality
  - Persistence: Bipolar moods last longer
  - Reactivity: BPD moods more reactive
  - Personality features may be state dependent on mood (e.g., more irritable when hypomanic)

Distinctions between BPD and BP II

Wilson, Stanley, Oquendo et al., 2007

- BPD patients:
  - Depression subjectively worse, even if observers rate it the same
  - More cognitive symptoms: guilt, depersonalization, paranoia, obsessing
  - More suicidal ideation
  - Greater anxiety
- Impulsivity:
  - Bipolar: greater cognitive inattention, distractability
  - BPD: greater problems with failure to realize consequences

The term "bipolar" is overused to describe mood fluctuation

Overlap with other PD's

Koenigsberg et al, 2002

Compared with other personality disorders, BPD shows

- greater lability and oscillation between moods
  - Depression and anxiety
  - Depression and anger
- Subjective intensity similar

Biological Research in BPD: Can it point toward specific medications?

- Chemistry: Traditionally looked to see if BPD had neurotransmitter abnormalities akin to those seen in Axis I disorders.
- Genetics: Could dimensions of personality be linked to heritable abnormalities?
- Function: New approaches looking more specifically at how the brain is regulated.

Neurobiology

Summarized by Siever and Davis; Lee and Coccaro

Apply Axis I paradigms to neurochemistry:

- Draw correlations from Axis II to Axis I categories, look for similar neurotransmitter abnormalities:
  - Cognitive disorganization (Cluster A) – compare with schizophrenia
  - Impulsivity/Affective lability (Cluster B) – compare with mood disorders
  - Anxiety (Cluster C) – compare with anxiety disorders
- Inconsistent findings for serotonin and GABA systems
- Greater sensitivity to DA stimulation in BPD patients prone to psychotic sx
- HPA axis may show increased CRF after early life stress in BPD adults

Heritability of dimensional traits, though not clearly linked to neurobiological substrates (Jang et al 1996; Bouchard and McGue, 2003)

- Openness: 57%
- Extraversion: 54%
- Conscientiousness: 49%
- Neuroticism: 48%
- Agreeableness: 42%

Functional anatomy

- Increased gray matter density of the amygdala, decreased for anterior cingulate gyrus, correlated with fear reactivity (Minzenberg et al 2007)
- Prefrontal cortex underactivation, limbic overactivation, associated with difficulty inhibiting negative emotion (Silberswelg 2007)

Neurobiology of the intersection between cognition and emotion

Silberswelg 2007, Siegle 2007

fMRI study of cognitive function in emotional context between BPD and normal controls

Methods

- Push a button for standard font, not italicized words
- Words could be neutral, positive, or negative

Results

- BPD pushed button too often, especially if the word was emotionally negative (i.e., inability to inhibit response)
- Also showed greater negative interpretation of words

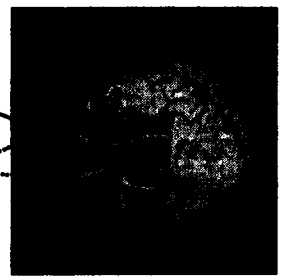
Normal mechanisms of inhibiting frustration

Orbito-frontal cortex normally dampens activation of limbic areas including:

- amygdala (emotions)
- dorsal-anterior cingulate (decisions)

fMRI findings in BPD compared with normal subjects

- Decreased activation of medial orbitofrontal cortex: deficit in the "top down" system that normally inhibits emotional response
- Increased activation of limbic areas, esp. amygdala: "bottom up" stimulation of behavioral response to misperceived stimuli



Commentary by Greg J. Siegle, Am J Psychiary 2007

Subjects with borderline personality disorder displayed brain responses associated with automatic emotional reactions; they may not have flexibly used brain mechanisms that would appropriately regulate these emotions.

We can begin to infer that when individuals with borderline personality disorder display decreased impulse control, this loss of impulse control may reflect a deficit in recruitment of brain mechanisms of emotion regulation, and this process may be potentiated by context. Particularly stressful or negative contexts could lead to more impaired impulse control.

How could this be modified with medication, or with psychotherapy?

What is the evidence for pharmacotherapy?

Challenges in research on medication

Cochrane Collaboration, 2008 and other sources

- "If offered medication, people with BPD should know that it is not based on good evidence from trials"
- Most studies focus on affect, aggression or impulsivity, not cognitive/perceptual or anxiety symptoms
- Most RCTs exclude suicidal patients
- Some exclude comorbid major depression
- Disorder fluctuates markedly over time; most studies are short term, last 8-12 weeks at most
- Rating scales
  - Most rating scales designed for Axis I disorders
  - Value of dimensional scales that are diagnostically neutral, e.g. Overt Aggression Scale (Yudofsky et al, 1986)
- Psychodynamic measures of character have not been examined
  - Defenses, self-concept, personality organization, etc.

Randomized Control Trials

Clinical Trials of Medication

Mercer, Current Psychiatry Reports, 2007:9:53-62

- Studies:
  - BPD with depressive symptoms
  - BPD with significant anger or impulsivity
  - BPD without depression
  - Interactions with psychotherapy
- Medications:
  - Antidepressants
  - Antipsychotics
  - Anticonvulsants
  - Others

Antidepressants

With depressive symptoms

- Randomized trials:
  - Combined benefits of fluoxetine and IPT for depression, anger, suicidality, neediness
  - No benefit added to DBT
- Open label
  - Fluoxetine better than tricyclics
  - TCAs may help depression but not other core sx
  - MAOIs variable; helped comorbid atypical depression, dysthymia, anger

Without depression

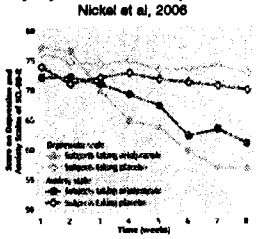
- Fluoxetine over 12 weeks at 60 mg helps impulsive aggression; moderate effects on mood lability

Atypical Antipsychotics

- Olanzapine
  - With depression: small effect on depression and anxiety added to DBT; not for aggression, self injury
  - Without major depression: Variable results in 3 studies of mood, anxiety, depressive symptoms
- Risperidone, uncontrolled: benefits mood, aggression, hostility, suspicion; RCT no benefit
- Aripiprazole RCT: large effect on depression, anger, paranoia; modest for anxiety
- Ziprasidone: Open studies show modest benefits on mood, agitation, anxiety, anger
- Clozapine: Beneficial in open studies; well tolerated at lower doses
- Quetiapine: 1 open study, improved anger, anxiety, but not depression, self harm, suicidality or impulsivity

Aripiprazole (Abilify)

Nickel et al, 2006



- 52 Subjects, 43 female with BPD; only 5 dropped out
- Improvement on SCL-90 subscales, STAXI, Ham-D and Ham-A (correlated with mood, aggression, cognition)
- No measurement of interpersonal functioning
- 18 month followup study showed continued benefit

First Generation Antipsychotics

- With depression: Haloperidol: mixed results for anger, not on anxiety or depression.
  - Benefits more apparent when schizotypal symptoms are present
- Without major depression
  - Thiothixene benefited psychotic symptoms
  - Trifluoperazine improved observer ratings only
  - Fluphenthixol decanoate reduced suicide attempts
  - 3 negative studies

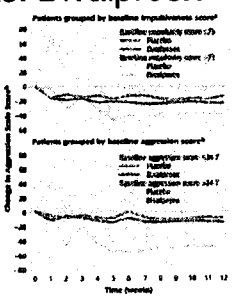
Combined SSRI-Antipsychotic

Zanarini et al 2004

- RCT 8-week comparison of
  - Fluoxetine
  - Olanzapine
  - Combination (Symbyax)
- 14-16 patients in each group
- Fluoxetine 10-30 mg, Olanzapine 2.5-7.5
- Olanzapine or combination better than fluoxetine along for aggression and dysphoria
- Less weight gain with OFC than Olanzapine

Anticonvulsants: Divalproex

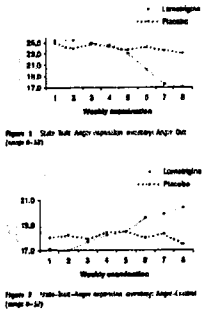
- 1 RCT in BPD showed positive effects in patients with more baseline trait impulsivity and state aggression (Hollander et all 2005)
- 2 studies on depression in patients with or without Bipolar II disorder inconclusive



Impact of Pretreatment Impulsiveness and Aggression Scores on Change in Aggression Scores of 50 Patients With Borderline Personality Disorder After Receiving Placebo or Divalproex Sodium for 12 Weeks

Lamotrigine

- 1 open study positive
- 1 RCT(Tritt et al, 2005)
  - 24 women with subjectively high anger
  - No major depression or bipolar disorder
  - 8 weeks, 200 mg LTG monotherapy by the end
  - Significant improvement in anger ratings
  - Note: other dimensions not evaluated (mood, anxiety, et
- Superiority of LTG to no Tx maintained over 18 months (Tritt 2008)



Lamictal

Improvement w/ aggression w/ women

Other mood stabilizers

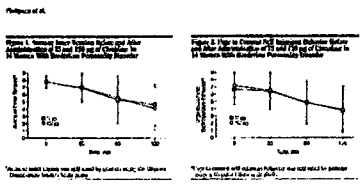
- Carbamazepine: 2 RCTs, mixed
  - 1 major finding was observer-rated improvement in aggression, but not subjectively improved
- Oxcarbazepine: no change in depression or functioning; anger, anxiety, interpersonal sensitivity improved
- Topiramate:
  - 2 RCTs in non-depressed men or women showed improved anger control
  - 1 RCT in depressed women showed no benefit in depression, but anger improved
- Lithium:
  - Superior to placebo in "emotionally unstable character disorder
  - No effect in BPD with dysthymia
  - Improved observer ratings but not subjective ratings in violent prison inmates

Other treatments

- Benzodiazepines
  - Alprazolam RCT: worsened suicidality; no effect on depression, anger, anxiety, interpersonal
  - Evidence for greater difficulty discontinuing
- Naltrexone/nalaxone: reduced self-harm in autism and developmental delay; 2 open studies in BPD suggest benefits for self-injurious behavior, no benefit for dissociative states
- Omega 3 fatty acids (fish oil): RCT without major depression, modest benefits on depressive symptoms
- ECT prospective study: less antidepressant response than patients with other PD or no PD
- Clonidine: open trial of "prn" showed decreased dissociation and suicidality over 120 minutes

Clonidine as a PRN

Philipsen et al 2004



- Limitations:
  - No placebo
  - Subjects in phone contact with therapist throughout the crisis

Practical Strategies: APA Practice Guidelines, 2001

APA approach: Target explicit BPD symptom clusters

- Affective dysregulation
  - Mood lability, anger, depressive mood crashes, temper outbursts
- Impulsive-behavioral dyscontrol
  - Impulsive aggression, self-damaging behavior
- Cognitive perceptual symptoms
  - Suspiciousness, referential thinking, paranoid ideation
  - *I would add developmental cognitive problems such as ADHD and learning disorders*

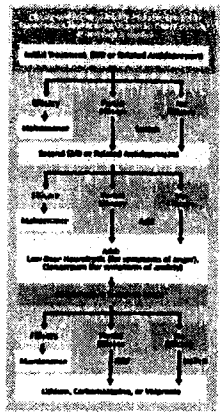
Algorithm for mood including emotional lability, rejection sensitivity, anger, mood crashes

Emphasis: SSRIs

Other possibilities:

Lamotrigine?

Non-SSRI's such as bupropion?



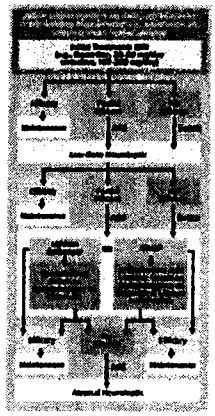
Algorithm for impulsive aggression including self-mutilation and reckless behavior

Emphasis: Move sooner from SSRIs to neuroleptics, mood stabilizers

Other possibilities:

Lamotrigine supported in recent clinical trials (Tritt et al, 2005, 2008)

Naltrexone (opiate antagonist)?

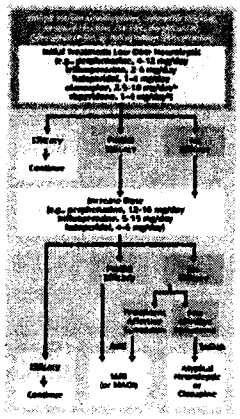


Algorithm for cognitive and perceptual problems (schizotypal, paranoid traits)

Emphasis: Neuroleptics

Comment: Consider a different picture, of non-psychotic cognitive problems as well, such as ADHD or learning disorders affecting personality and daily functioning;

Consider treatment with stimulants?



What do clinicians actually do?
Do symptom clusters predict medication choice?
Oldham, Bender et al 2004

Medication Class	Cognitive-perceptual $n = 101$	Affective dysregulation $n = 48$	Impulsive-behavioral $n = 23$
SSRI ($N = 138$)	79 (78.2)	36 (75.0)	17 (73.9)
Neuroleptics ($N = 66$)	44 (43.6)	19 (39.6)	13 (56.5)[b]
Anticonvulsants ($N = 78$)	47 (46.5)	18 (37.5)	18 (78.3)[c]
Lithium ($N = 34$)	18 (17.8)	6 (12.5)	5 (21.7)
Clonazepam ($N = 63$)	36 (35.6)	18 (37.5)	6 (26.1)

[a] *Individual patients may be represented in more than one symptom cluster category.*
[b] $p < 0.05$ (*Chi-square = 3.99, df = 1*)
[c] $p < 0.001$ (*Chi-square = 12.17, df = 1*)

Practical Strategy from personal experience:
Frame the treatment in communication between professionals, and with patients and their families

- Establish a general model of what we are treating
- Avoid the mind/body problem
- Diagnose and treat comorbidity
- Set realistic goals with the patient
- Target BPD symptom clusters
- Manage expectations

General Model

- Genetic predisposition to dysregulation of some key function, e.g.
  - Affective intensity
  - Cognition
  - Perception
- Environmental reinforcement of latent negative traits via
  - actual external trauma, loss, stress
  - and/or the feedback consequences of the disorder itself
- Frequent comorbidity with better-defined Axis I disorders

Avoid mind/body problems

- It does not matter if the symptoms are "biological" or "psychological" - try to remain agnostic
- This is empirical, and every treatment is an experiment
- This is to help symptoms, not to explain their cause
  - E.g., treating a depression does not deny the reality of losses that precipitated it; using an anticonvulsant for aggression does not mean the person has no responsibility
- If a medication helps enough to warrant the risks and side effects, that is progress
- If not, we won't continue it

Treat comorbid disorders

Diagnose and treat well-defined comorbid disorders appropriately

- Major depression and dysthymia
- Bipolar I and II, cyclothymia, NOS
- Anxiety disorders
- Substance abuse, including unusual sensitivity to "normal" amounts of alcohol and illicit drugs
- Eating disorders
- Brief reactive psychosis
- ADHD and learning disability

Set realistic goals

- Medication goals are modest but even partial relief may help to advance broader therapeutic goals and ability to engage in treatment
- Think of stages of treatment to evaluate whether or not a medication is working
  - Short term crisis management and "prn" relief
  - Longer term effects on inherently fluctuating states
  - Comorbid Axis I disorders

Manage expectations

- Don't expect miracles but maintain hope
  - Set realistic goals, neither too ambiguous nor ambitious
  - Expect fluctuation as part of the illness
  - "We've been here before; it will get better again"
- Prepare for greater sensitivity to side effects
  - Subtle or profound CNS adverse reactions
  - Begin with lower doses than in Axis I disorders, increase slowly
- All uses are off-label, except Axis I indications

Conclusions

- Treatment targets symptom domains and comorbid disorders
- No treatments have been studied for global effects on interpersonal function
- Benefits tend to be modest and highly variable
- Stay pragmatic, avoid over-medication; though some combination is par for the course

March 28, 2009
Columbia CME Conference
Cutting Edge Treatments for Borderline Personality Disorder

Syllabus
David A. Kahn, M.D.
Current Medication Strategies

1. There are no medications for Borderline Personality Disorder (BPD) per se.
2. Comorbidity with well-defined Axis I disorders is the rule, not the exception. The course of Axis I disorders and BPD tend to occur in tandem – remission in one is associated with improvement in the other; therefore, it is vital to treat Axis I disorders with appropriate medications.
3. The evidence base for effectiveness of medication in BDP is generally thin, owing to the variable course of the illness itself and difficult-to-define endpoints. Attached are three good reviews of the available evidence. Of note, there are no FDA approved medications for BPD.
4. Despite the dearth of solid evidence, a common general approach is to target symptom clusters within BDP:
    a. Mood symptoms
    b. Aggression and impulsivity
    c. Cognitive and perceptual
5. Antidepressants, especially SSRIs, are the traditional mainstay for mood symptoms and to some extent aggressive and impulsive symptoms, while antipsychotics have been used more for cognitive and perceptual symptoms. There is some evidence that anticonvulsants and antipsychotics may have broader value for mood and aggression than previously appreciated.
6. Medication treatment needs to occur in the context of a solid psychotherapeutic treatment structure, and should be accompanied by realistic goals and reassessments of progress to avoid unwarranted polypharmacy.

References attached:

Binks CA, Fenton M, McCarthy L, Lee T, Adams CE, Duggan C. Pharmacological interventions for people with borderline personality disorder. Cochrane Database Syst Rev. 2006 Jan 25;(1):CD005653

Raj PR. Psychopharmacology of borderline personality disorder. Curr Psychiat Reports 2004; 6:225-231

Abraham PF, Calabrese JR. Evidence-based pharmacologic treatment of borderline personality disorder: A shift from SSRIs to anticonvulsants and antipsychotics? J Aff Disorders 2009; 111:21-30

I have also included in this syllabus the webpage for the Columbia Day Treatment Program, which offers intensive group therapies, including DBT, for complicated patients. Individual referring therapists continue their work privately while patients participate in the program.

Cutting Edge Treatments for Borderline Personality Disorder:
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Saturday, March 28, 2009

Dialectical Behavior Therapy (DBT) Strategies for Every Clinician

Barbara Stanley, Ph.D.

Dialectical Behavior Therapy: Strategies for Every Clinician

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- Special Acknowledgement: Our patients and research participants

Focus of Presentation

- Challenges and possible solutions to working with multi-problemed patients who walk a tightrope between life and death
- How a DBT approach can shape and improve our thinking about suicidal patients, self-injuring patients, and patients with BPD
- Techniques that can be incorporated into a "non DBT" treatment
- Adapting a "DBT style" for brief interventions with suicidal patients to maintain safety and enhance self-efficacy

What is DBT?

- Form of cognitive-behavior therapy developed by Marsha Linehan, Ph.D. to treat self-injurious behaviors including suicidal behavior
- Specifically for individuals diagnosed with borderline personality disorder (BPD)
- Designed as an outpatient treatment---major advance because suicidal individuals were typically hospitalized

Borderline Personality Disorder

- Fear of abandonment
- Idealization/devaluation
- Identity disturbance
- Impulsivity
- Recurrent suicidal behavior
- Affective instability
- Emptiness
- Inappropriate, intense anger
- Transient, stress-related paranoia or dissociation

BPD as a Disorder of Dysregulation

- Emotional dysregulation
  - Affective instability, anger
- Behavioral dysregulation
  - Impulsivity, suicidal behavior
- Cognitive dysregulation
  - Dissociation, paranoia
- Interpersonal dysregulation
  - Abandonment, splitting
- Dysregulation of self
  - Identity disturbance, emptiness

Questions most often asked by mental health professionals about working with individuals with BPD

- How does a therapist maintain empathy for their patients with BPD when the demands can be so great?
- How do you make progress toward significant change when there are so many crises?
- How do you manage non-suicidal self injury, chronic suicide ideation and behavior in an outpatient treatment?
- How do you set limits when you fear it will trigger suicidal behavior or turn down a request when patients with BPD are so sensitive to rejections?
- What are the guidelines for knowing when to hospitalize and how to most effectively make use of hospitalization for these patients? How can you avoid unhelpful, repeated hospitalizations?

Questions most often asked about working with individuals with BPD (cont'd)

- How do you offer availability while placing manageable limits on between session phone calls and requests for contact?
- How do you balance need for support (dependency) and autonomy in treating BPD patients?
- How do you assess capability in patients with BPD and set realistic goals?

Developmental Model of BPD
Basic Deficit=Affect Defect

Biological predisposition and/or chronic early stressors

↓

Extreme difficulties in "Emotional Learning"
Similar to being overwhelmed/flooded response to acute stress

↓

"Emotional Dyslexia" -- Difficulty processing emotions

↓

Development of "unintegrated" positive and negative affective states
[Akin to positive & negative symptoms in schizophrenia]

Positive and Negative Symptoms in BPD

Positive symptoms:
Impulsivity, Anger, Self injury

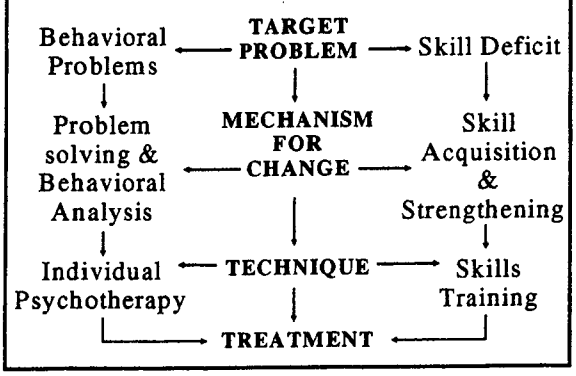
Negative symptoms:
Dissociation, Identity diffusion, Emptiness

Combination/Alternating symptoms:
Unstable relationships, Affective lability, Abandonment, Black and white thinking

Implications of the Affect Defect Model

- Deficit model
- Appropriate therapeutic approach: deficit reduction
- Patient reports: "I know all about why I'm doing what I'm doing, I just don't know what to do instead."
- Alternate responses: "You just don't know enough" vs. "Let's figure out what to do instead then."

DBT's Two Prong Approach



Key Components of DBT

- Combination of individual psychotherapy and skills training
- Focus on behaviors as the vehicle to discussion of affects
- Individual psychotherapy utilizes a hierarchy of behaviors. The hierarchy serves as the "agenda setter" within each session and over time

Key Components of DBT (cont'd)

- Hierarchy of behaviors provides "road map" for both the patient and therapist
- Individual psychotherapy utilizes behavioral and solution analysis based on diary card and patient reports
- Skills training is equivalent to a seminar; not group psychotherapy
- Skills training consists of four modules: distress tolerance; interpersonal effectiveness; emotion regulation; mindfulness

Key Components (cont'd)

- Consultation team utilized to provide support to therapist and to help therapist stay on track --- with observing limits and adhering to hierarchy
- Contact between sessions:
  - To help patient learn and apply skills (generalization of skills)
  - To increase "skillful" behavior with regard to asking for help appropriately
  - To repair the therapeutic relationship

• radical acceptance
this is what happened
now what do I do!

DBT Approach #1: Maintaining Empathy

- Reconceptualize patient's difficulties in terms of skill deficits
- Shifts feelings, increases empathy
- Case example

patient gets upset w/something you say, yells at you, feels suicidal, storms out of office, skills
• aggressive, controlling, manipulative vs

DBT Assumptions Increase Empathy

- Patients are doing the best they can
- Patients want to improve
- Patients need to do better, try harder, and be more motivated to change
- Patients may have not caused their problems but they have to solve them anyway
- Patients' lives are unbearable as they are currently being lived
- Patients must learn new behavior in all relevant contexts

DBT Assumptions (cont'd)

- Patients cannot fail in therapy – the treatment fails
- Therapists treating multi-problemed patients with chaotic lives need support

DBT Approach #2
Dealing with Chaos and Continual Crisis:

Organize an orderly treatment

Use a roadmap

When working with patients with continual crises and continual stressors: Stay on the path to change or get derailed by moment to moment crises

VS

Strategies for avoiding continual detours and never getting anywhere

Develop a clear and agreed-upon hierarchy of goals for treatment and stick to it (flexibly):

1. Reducing life-threatening behaviors
2. Reducing therapy interfering behaviors
3. Achieving stability and reducing quality of life interfering behaviors---substance use, work/school problems, relationship problems

Structuring Techniques

- Use Diary Cards
- Set Agendas
- Conduct Behavioral Analysis
- Balancing validation with problem solving

ILLUSTRATION OF A DIARY CARD WITH AN EPISODE OF SELF-INJURY

Date	Alcohol	Over the counter medications	Prescription medications	Illicit Drugs	Suicidal Ideation (0-6)	Misery (0-5)	Non-suicidal self-harm	Non-suicidal self-harm	Binge behavior
							Urges	Action	
Mon	0	0	Took them	None	1	3	0	N	Y
Tues	0	0	Took them	None	1	3	0	N	N
Wed	4 drinks	0	Took them	None	2	4	0	N	Y
Thurs	0	tylenol	Took them	None	4	5	6	Y	Y
Fri	0	0	Took them	None	1	3	0	N	N
Sat	2 drinks	0	Took them	None	0	2	0	N	N
Sun	0	0	Took them	None	2	3	0	N	Y

Agenda Setting

- Review of diary card
- Consider agenda in the context of goals:
  1. Reducing life-threatening behaviors
  2. Reducing therapy interfering behaviors
  3. Achieving stability and reducing quality of life interfering behaviors---substance use, work/school problems, relationship problems

Behavioral Analysis

- What is it?
  - Major technique to gather information about a problem behavior (including urges and negative feelings)
  - Systematic approach to determine the chronology of events that results in problem behavior
  - Therapeutic tactic to effect change

Behavioral Analysis

- How is it done?
  - Collaboration between therapist and patient
  - Problem behavior to analyze is identified
  - Therapist inquires about thoughts, feelings, environment and behavior in chronological order
  - Therapist writes down patient's responses and each behavioral analysis becomes part of a data bank for the patient therapist dyad
  - As patients become more experienced, they can perform their own behavioral analysis outside of sessions and bring them to sessions for elaboration

Steps in Behavioral Analysis

- Identify the behavior to be analyzed and have patient describe what happened (e.g. for self injury: was upset, went to room by self, got razor from bathroom, sat on bed and cut forearm several times, felt better.
- Identify Vulnerability Factors in Self and Environment ---
  - Self examples: physical illness, fatigued, PMS, depressed mood.
  - Environment examples: Anticipation of anniversary date, upcoming exams, loss of a job or new job, ongoing family problems

Behavioral Analysis (cont'd)

- Identify Immediate Precipitants --- Examples: argument with someone, someone let patient down, poor exam grade, trying but unable to get work done, intolerable anxiety, feeling envious and then feels guilty.

Behavioral Analysis (cont'd)

- Choose a starting point---work forward or backwards from the problem behavior
- Obtain description of all thoughts, feelings, behaviors, and events that happened along the chain leading to the behavior
- After complete description is obtained, have patient detail the positive and negative consequences in environment and self
- Plan for repair, overcorrection and anticipation of how to not engage in problem behavior in future

Behavioral Analysis (cont'd)

- As the chain is described, therapists and patients generate "solutions" that could have interrupted the chain. Questions such as, "What could have been done instead of.....?" or "What skill/way of coping could you have used at this point?"
- For behavioral analyses early in treatment, therapists generate most or all of the solutions; as the treatment progresses, it becomes more of a 50-50 proposition and eventually patients generates most of the solutions; i.e. Shaping of the behavior takes place

Behavioral Analysis (cont'd)

- Early in treatment, chains leading to problem behaviors begin to be interrupted close to the behavior; as treatment progresses, interventions come earlier and earlier in the chain; patients learn to identify what starts them down a dangerous path

Obstacles Encountered in Conducting Behavioral Analyses

- Patients feel that nothing happened that led up to the behavior. "It just happened." "I don't know what I felt." "I can't possibly figure out what I was feeling."
- Patients can't remember the events in the chain/patients report having been dissociated
- Patients don't want to construct the chain
- Patients become aroused, overwhelmed or dissociated during chain

When Behavioral Analysis Can Be Used

- When any problematic behavior that occurs on a frequent basis (infrequent, if severe) and the goal is to reduce or eliminate that behavior
- Life threatening behaviors ought to be addressed first.
  - e.g. if patient is routinely cutting self and having a lot of arguments with boyfriend, cutting is addressed first even if patient wants to address arguments
  - Most often, the arguments will become part of the chain but priorities are clear---it's more important to not cut yourself than to not have arguments with boyfriend

Case Example

- 25 year old female; hx of depression and BPD
- Lives in an apartment with a roommate
- Did extremely well in school; completed law school and now has first job in a prestigious law firm
- Begins dating a man; has three dates; feels that she is falling in love; she begins to get worried that he doesn't really like her; she becomes suicidal
- Went home one day when she expected his call, he didn't call
- Goes to bathroom, takes razor and puts a series of cuts on the inside of both thighs
- When asked about why, she reports, "It just happened."

Case Example

- Vulnerability Factors in Self: PMS, feeling ill
- Vulnerability Factors in Environment: Two childhood friends recently engaged, argument with roommate
- Precipitating Events: No call from man she'd started dating
- Chain: Behaviors, Thoughts, Feelings and Reactions: Went home after work and didn't go out to a movie with coworkers because she wanted to be available for boyfriend's phone call;
- Target Event: Razor cuts on inner thighs
- Aftermath: Felt better

Chain: Behaviors, Thoughts, Feelings and Reactions

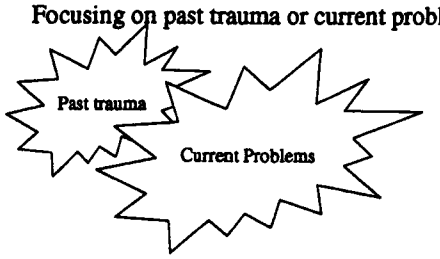
- Went home after work and didn't go out to a movie with coworkers because she wanted to be available for boyfriend's phone call
- Waiting for the call, felt hopeful and excited
- Within a short time without a call, began to feel "like a fool" that he was never going to call, felt that she couldn't stand waiting, couldn't do anything but sit and wait and feel anxious
- Thought he must that she's ugly and undesirable
- Thought she must be undeserving and unlovable
- Felt anxious, "bad, intolerable" feeling
- Went to bathroom and made several cut
- Aftermath: Felt better, cleaned up, went to sleep

Summary of Behavioral Analysis

- Behavioral analysis is a powerful technique:
  - to gather information
  - to equip patients to understand themselves and analyze their behaviors on their own
  - to effect change and eliminate/reduce problem behaviors
- It is a collaborative, problem-solving, respectful, non-mysterious and non-judgmental approach that can be extremely helpful.

Roadmap Approach

Focusing on past trauma or current problems?



DBT Approach #3: Validation

- Validation means to acknowledge that another's or one's own responses make sense and are understandable within a current life context or situation

Levels of Validation

- Level 1 – Therapist appears interested, stays awake, listens
- Level 2- Accurate reflection
- Level 3 – Correct articulation of thoughts/feelings that have not been fully expressed ("mindreading" or accurate interpretation)
- Level 4 – Behavior makes sense in terms of past learning or biological factors
- Level 5 – Client's responses makes sense in terms of current events (normalization)
- Level 6 – Therapist is radically genuine with client
  Treating the whole person as valid, confrontation, cheerleading, expressing belief in the client, not treating with kid gloves.

Validation exercise

- A 24 year old single woman was rejected by a guy she was "dating". One night, she got very drunk, went to his home, banged on the door when he didn't answer the bell. He yelled at her from the other side of the closed door to go away. After about 30 minutes of trying to get him to let her in, she went home, called her mother to tell her she was going to kill herself, then cut herself superficially on the arm with a knife and fell asleep.

's validate that they want to & deserve to feel better, but need to find a better approach

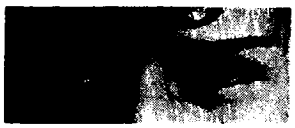
DBT Approach #4: Therapist Stance

- Be genuine
- Be transparent: Explain what you're doing and why (e.g. diagnosis, approach to phone contact, rationale for agenda setting)
- Extend yourself but observe personal limits- extending too much is a disaster
- Use intersession contact effectively
- Utilize peers routinely
- Don't be simply supportive---treatment will ultimately feel useless ⇨ ⇧ hopelessness

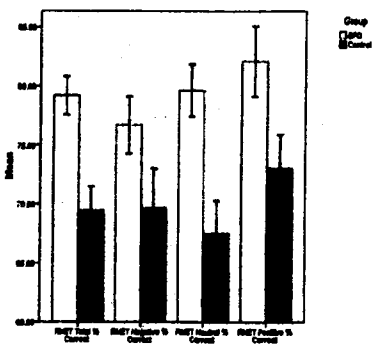
Facial Emotion Recognition

- We utilized the Reading the Mind in the Eyes Test to assess sensitivity to facial emotional expression in BPD and Healthy Controls.
- The test presents participants with thirty-six pictures of the area of the face immediately surrounding the eyes.

Example of facial stimuli from the Reading the Mind in the Eyes Test
(Baron-Cohen, Wheelwright, Hill, Raste, & Plumb, 2001)



1. Playful
2. Comforting
3. Irritated
4. Bored



DBT Consultation Team

- Provides support and supervision;
- Helps therapist maintain validating stance;
- Helps therapist balance validation with change.

Balancing acceptance with change

- **Acceptance** of whatever is valid about the individual's current behaviors, viewing these behaviors as the patient's best efforts to cope with unbearable pain.
- **Change** is achieved through the tension and resolution of essential conflict between acceptance of the individual as they are right now, and demanding that they change.
- **Dialectics** encourages cognitive restructuring from an either/or to a yes/and perspective – directly addressing the dichotomous thinking that is characteristic of individuals with BPD and which often leads to maladaptive behaviors.

Managing Suicidal Behavior in BPD

tf
'24 hour rule'
↳ call when want to
Self-harm
↳ if self-harm then
no contact for 24 hours

Managing suicidal behavior

- Bias to keep patient out of hospital if possible.
- Consultation to third party
- Managing contingencies
- Providing support

Identifying and Managing Suicidal Behavior

- Assessment – ask about Suicidality regularly
- Management
- Safety planning

Clinical Approach: Assessment

- Assess **current** level of risk
- Distinguish between suicidal and non-suicidal self injury
- Risk assessment includes evaluation of suicidal intent and lethality of the self harm behavior
- Also includes reasons for staying alive---children and religion are powerful as is some hope about the future
- Current suicide status---can be diminished in BPD following attempt

Treatment Recommendations

- Determine immediate level of care required--- "least restrictive means"
- Typical options: inpatient hospitalization; IOP; day program; outpatient treatment
- Consider range and intensity of outpatient treatments
- Develop safety plan
- Safety plan = management strategy of suicidal crisis
- Implementation of the safety plan IS treatment and helps patients "survive" suicidal urges

Safety Plan

- Crisis plan should/when suicidal urges re-emerge
- Developed in a collaborative manner
- Plan is a written document
- Safety plan is NOT the same as a "no-suicide" contract---not so useful because it includes a promise but not how to uphold the promise

Safety Plan (cont'd)

- Arrange to "cleanse" environment
- Safety plan includes a step-wise increase in level of intervention from "within self" strategies up to going to psychiatric ER
- Although a safety plan is step-wise, it doesn't mean that if one step is unavailable that the person stops there

Safety Plan (cont'd)

- "Within Self" strategies---
- Question to patient: "What can you do, on your own, if you get suicidal again to help yourself not act on urges?"
- Examples: Listen to music, go online, go for a jog, watch television (e.g. cartoons, comedy), take a shower, pray
- Develop an order of priority to implement strategies

Safety Plan (cont'd)

- Strategies Involving Others----
- Identify key figures who can be enlisted to help
- Try to have several people on this list
- Initial level of "Other" involvement can be using others as distractions and feeling connected; does not include revealing suicidality

Safety Plan (cont'd)

- Next level of Other involvement includes revealing suicidal feelings
- Choose others wisely
- Stepwise increase in involvement from natural support group to professionals to hospital

External Involvement

- Friends
- Family
- Hot line
- Therapists
- ER

- Be specific---Include names, phone numbers, locations
- Order in priority

Case Disposition

- Emily reported that she had intended to kill herself but was no longer suicidal
- She felt "better" and "restored" after the self injury event
- Agreed that she should be in therapy
- Discharged from ER with rudimentary safety plan
- Extensive safety plan developed with outpatient therapist as the first task

Example of Safety Plan

1. Remove exacto knives, razors and scissors
2. Go online and play Tetris
3. Listen to IPOD (skip morbid tunes)
4. Go for walk in park
5. Call friends to check in and as distraction: Jennifer, Amy, Joanie
6. Contact friends, Amy or Joanie, to ask for help
7. Contact therapist to ask for help---Phone and Pager #'s
8. Contact mother
9. Go to ER---Name of closest hospital and address

Conclusion

- DBT is treatment that is well-tolerated by patients and therapists
- Some of the techniques may be incorporated into clinical practice even when not doing "DBT by the book"

Cutting Edge Treatments for Borderline Personality Disorder:

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Saturday, March 28, 2009

NOTES

"on vacation" - out of therapy until certain behavior starts/stops

"fired" - therapist no longer able/willing treat patient
- ↳ aggressively violates limits (therapist's)
- ↳ unethical - treatment will not help

↳ failure of therapist

afraid of getting better
~~be~~ get better once you get better u will be happier
- ↳ afraid of walking through burning door to get out of burning building

need to overcome fear...

~~irrelevant~~ 'irrelevant lives'

* Don't try to control patient - "I can't make you not die"

highlight their behavior and affect on you.
- ↳ give information why don't you want to go
- ↳ don't try to get to go for themselves

Think like salesman!
- ↳ make task hard to get into
- ↳ ~~make it look~~ associate treatment you want to get into with good things

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NOTES

Behavioral/techresearch.com.

observe limits - Do not set limits (punishment)

high risk of suicide ~~on~~ with in patient

i.e. 'if has fantasies/hi/s/etc she has go back to her own apt for 1hr. then she could come back"

by setting/contracting/helping regulate reinforcer bad behavior

- Borderlines are not necessarily manipulative
- ~~Border~~ BPD not stigmatized
- Judgemental culture
  - need to learn evidence based treatment

Dissociative behavior is 'automatic' escape behavior