Good Psychiatric Management:
What every psychiatrist should know

John Gunderson, MD
Good Psychiatric Management

Section 1: Background
BPD: Status

• Prevalence ~ 20% clinical visits, ~ 2.5% of population

• Health Care Burden
  - escalating costs
  - inconsistent, even harmful care

• Lack of treaters

• Psychiatry needs to adopt the diagnosis
  - genetics without psychopharm
  - sustains psychological & social perspective
  - personal involvement required
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 adequately trained BPD treaters
MYTHS ABOUT TREATMENT OF BPD

1. BPD patients resist treatment

   ● Most actively seek relief from subjective pain, treatment for their personality disorder requires education by clinicians.
   ● Non-compliance is likely when treatment is ineffective.
I DON'T FEEL LIKE WE'RE MAKING MUCH PROGRESS WITH MY ABANDONMENT ISSUES, DOCTOR...
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
MYTHS ABOUT TREATMENT OF BPD

2. BPD patients angrily attack their treaters
   - Excessive anger and fearful wariness towards others, perhaps especially caregivers, are symptoms.

3. BPD patients rarely get better
   - About 10% remit within 6 months, 25% by a year, and 45% by 2 years -- even without extended or stable treatment.
MYTHS ABOUT TREATMENT OF BPD

4. Recurrent risk of suicide burdens treaters with excessive responsibility and the ongoing risk of litigation
   - These burdens are symptoms of treatments that are poorly conducted.

5. BPD patients get better only if given extended, intensive treatment by experts
   - Such treatment is only required by a subsample. Intense treatments can easily become regressive.
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-injurious 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.

B orderline 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 superiori-
GENERAL ("GOOD") 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
GOOD PSYCHIATRIC MANAGEMENT (GPM): Structure

- Once weekly individual *(if useful)*
- Psychoeducational
- Psychodynamic *(unrecognized motives, feelings; defenses related to IHS)* & behavioral *(accountability, contingencies)*
- Often includes medication management, PRN family interventions
- Split treatments desired *(especially groups)*
GPM’S RELATION TO OTHER EBT’S

• What BPD patients should expect their treaters to know
• Good enough for most BPD patients
• Those who fail → DBT, MBT, TFP, etc.
GPM: SIMILARITIES WITH OTHER EBTs

TFP – interpretative stance, appreciates covert aggression

DBT – education, homework, dyadic collaboration, concern with contingencies, reinforcement

MBT – informality, curiosity (not knowing), dyadic, active, patients’ anger as reactive
GPM’S DISTINCT FEATURES

Case management – focus on life outside treatment, psychotherapy adjunctive

Psychoeducation - genetics, course, social handicaps

Progress - determines duration and intensity

Interpersonal hypersensitivity – explains emotional and behavioral shifts

Flexibly multimodel - medication, groups and family interventions are encouraged
GPM Handbook vs. “General” PMs Manual

• Patients don’t sign consents or contracts

• To facilitate learning, not to monitor adherence or proscribe non-GPM interventions

• DSH/suicide behaviors less emphasized

• Interpersonal context emphasized
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Section 2: Interpersonal Hypersensitivity
INTERPERSONAL RELATIONSHIPS

(a unique domain for psychopathology)

- Both within the person and outside the person (i.e., me in relation to others)
- Only observable within interpersonal interactions
- Inherently context-dependent (i.e., the other)
INTERPERSONAL HYPERSENSITIVITY
AS BPD’s 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
TRANSITIONAL RELATEDNESS
(a paradigm for BPD’s relationships)

• Both *within* and *outside* the person
• First “not me” object
• Not recognized as “not me” – creative, imaginative, mental
• Secondary to “good enough” mothering, i.e., healthy, disillusionment

Winnicott, Int J PSA, 1953
BPD’s Interpersonal Hypersensitivity: Neuropeptide Markers

- Low opioids - \( \uparrow \) sensitivity to rejection and abandonment
- Low oxytocin - \( \uparrow \) social sensitivity; distrust and antagonism
- High vasopressin - \( \uparrow \) anger within close relations

Stanley & Siever, Am J Psychiatry, 2010
“Of course I love you—I’m programmed to love you. I’m a goddam lovebird.”
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**

**Connected**
idealizing, dependent, rejection-sensitive

Interpersonal Stress (perceived rejection, hostility, separation, criticism)

**Threatened**
devaluvative, self-injurious
angry, anxious
help-seeking

Support by the other (↑ involvement, rescue)

Withdrawal by the other (physical or emotional)

**Aloneness**
dissociation, paranoid
impulsive, help-rejecting

Holding (hospital, jail, rescuer)

**Despair**
suicidal, anhedonic
GPM & INTERPERSONAL HYPERSENSITIVITY

• Patients’ sensitivity/reactivity to being “held” predicts/explains phenomenology: emotional/behavioral dyscontrol are 2° interpersonal stress

• Dynamics (meanings):
  a) Unacceptable anger or passivity → “badness”, or if projected → “victim”
  b) Attachment = dependency, exploitation or inseparability, agreement

• Behavior: access to treatment is contingent, insight’s use is assessed by behavioral change
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Section 3: Overall Principles
SIX PRINCIPLES OF GPM

1. Be Active (responsive, curious), not reactive

- challenge passivity, avoidance, silences, diversions

- you are “the container” (cautious, thoughtful, “hold” projections)
2. **Support** - via listening, interest, selective validation
Support: Validation

• Seeing the patient’s description as legitimate and understandable (by you AND by the patient)

• NOT the same as agreeing – often requires “not knowing”

• Orients therapist and patient to collaboratively “make sense”
SIX PRINCIPLES OF GPM

3. Focus on life situations – relationships and vocation
   - Work > love

4. The relationship is real (dyadic) and professional -- selective disclosure (e.g., “you scared me”, “that would make me angry”)

5. Change is expected

6. Accountability – expect patients to be active within treatment, in controlling their life (agency)
ANGER MANAGEMENT

VIDEO
Illustrating ...

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

• Education is essential – even when seemingly ignored

• “Non-specific factors are central – reliability, listening, concern

• Relational issues are central – attachment, trust, positive dependency

• Situational changes can be essential – advise, exhort, assist

• Pragmatism – every patient is different; forego theory if it isn’t working; if not now – wait
GPM: THERAPEUTIC APPROACH: II

- The inquisitive stance: your life is interesting, important, and unique

- External → internal; implicit → explicit (Gabbard)

- Actively address here-and-now interactions
  - not knowing (MBT)
  - interpretation (TFP) -- best offered via questions

- Actively address negative “transference” – impatience, disdain; “Did I trouble/bother you?”
Therapeutic Approach: Building a Narrative

("I’d like you to be able to make sense of yourself and your life")

• Autobiography
• How does this relate to
  - “last session”
  - “past experience”
• “Have you noticed a pattern”?  
• That seems to recur whenever
  - “you start work (etc.)”
  - “I go away (etc.)”
• Chain analyses
# SEQUENCE OF EXPECTABLE CHANGES

<table>
<thead>
<tr>
<th>Target Area</th>
<th>Changes</th>
<th>Time</th>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Subjective distress/dysphoria</td>
<td>↓ anxiety &amp; depression</td>
<td>1-6 wks</td>
<td>support, situational changes, ↑ self awareness</td>
</tr>
<tr>
<td>2. Behavior</td>
<td>↓ self-harm, rages &amp; promiscuity</td>
<td>2-6 mos</td>
<td>↑ awareness of self &amp; interpersonal triggers</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>↑ problem solving strategies</td>
</tr>
<tr>
<td>3. Interpersonal</td>
<td>↓ devaluation, ↑ assertiveness, &amp; &quot;+ dependency&quot;</td>
<td>6-12 mos</td>
<td>↑ mentalization, ↑ stability of attachment</td>
</tr>
<tr>
<td>4. Social function</td>
<td>school/work/domestic responsibilities</td>
<td>6-18 mos</td>
<td>↓ fear, failure &amp; abandonment, coaching</td>
</tr>
</tbody>
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Three Processes of Change

• “Think First” – cognitive learning

• “Get a Life” – social rehabilitation

• Corrective experiences – therapist as caretaker (trustworthy) and role model (problem solving)
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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.”

“I’m filled with poison. It’s not my fault I’m poisonous.”
“She’s a psychopathic, delusional, borderline personality—and I can say that because I’m a psychopathic, delusional, borderline personality myself.”
SOURCES OF STIGMA

• Countertransference reactions to anger, neediness
• The perception of willful treatment resistance ("help rejecting complainers", "intractable", "emotional hypochondriacs")
• Cross-sectional exposure ("frequent flyers")
• Misinformation about heritability and prognosis
• Unrealistic expectations of competence
• PD’s are character flaws ("irresponsible," "fickle", "egocentric")
• BPDs self concept ("bad", "evil")
GENETIC DISPOSITION

• Heritability ~ 55% (> MDD, < Schizophrenia)

• Affective, Impulsive, Interpersonal and Cognitive elements are united by a latent core factor

• Two candidates for the genetic “Core”:
  - dysregulated emotionality
  - interpersonal hypersensitivity
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

Relapse defined as:
- ≥ 12 month
Mean GAF Scores

Study Year

Baseline 1 2 4 6 8 10

Gunderson et al., Arch Gen Psychiatry 2011
Functional Outcome @ 10 yrs

- BPD often involves chronic impairment (> 60%)
- BPD Remission → ↑ function
- Better function → ↓ criteria (?
- Predictors: ↑ work, education, ↓ age

Gunderson et al. Arch Gen Psychiatry, 2011
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’m BPD, I have it.”

“Getting the diagnosis explains so much. I couldn’t make sense of my experience. I’m not just crazy.”

“Isn’t bipolar II you’re depressed and then you’re not and then you get medications.”
BPD Criteria
(divided into component phenotypes)

• Interpersonal Hypersensitivity
  - Abandonment fears
  - Unstable relationships (ideal/devalued)
  - Emptiness

• Affective/Emotion Dysregulation
  - Affective instability (no elations)
  - Inappropriate, intense anger

• Behavioral Dyscontrol
  - Recurrent suicidality, threats, self-harm
  - Impulsivity (sex, driving, bingeing)

• Disturbed Self
  - Unstable/distorted self-image
  - Depersonalization/paranoid ideation under stress
DIAGNOSIS DISCLOSURE

VIDEO
Illustrating …

• Enlisting collaboration (*alliance building*)
• Usual acceptance
• Use of (*encouraging*) a developmental narrative
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)

Rubovszky et al. unpublished
PSYCHOEDUCATION FOR BPD

- 30 with workshop about BPD vs. 20 wait listed
- PE decreases impulsivity and unstable relations over next 12 weeks
- “a useful and cost efficient form of pre-treatment”

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Section 5: 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 (e.g., anger, self-harm) and relationships (e.g., distrust, control) are getting better.”
Early Markers of Progress
(If the answer is “no”, clinicians should explicitly review whether treatment is useful)

• 6 weeks: i) has the patient’s acute distress diminished?; ii) is the patient actively participating; iii) do you like the patient.

• 3 months: i) has self-injurious behavior decreased; ii) does the patient remember and apply lessons learned in sessions?; iii) has your understanding and empathy increased?

• 6 months: i) has the patient assumed/resumed social role/responsibility?; ii) does the patient relate behaviors or emotions to interpersonal events?; iii) has the patient’s trust in you (e.g., reliable, well-intentioned, caring) improved?
PHASES OF THERAPY

I. Building a contractual alliance: engagement - agreeing on goals and roles (1-3 mo)

II. Building a relational alliance - liking, trusting intentions (1-12 mo)

III. Positive dependency - explicit, comfortable (6 mo to 2.5 yrs)

IV. Becoming non-borderline (recovery) - generalize learning (2-10 yr)
GPM: ALLIANCE BUILDING

• Address CC: subjective distress & ADL’s (*sleep, diet*) - medications?

• Psychoeducation (*hope*): origins, course, treatment

• Enlist patients’ involvement
  - homework (*autobiography, safety plan, Sx diary, chain analyses*)
  - email

• Address situational stressors (*conjoint calls or meetings*)

• Availability: “Yes, but …”
GPM Goals

• “Getting a life” (partnership and social role) is a required goal!

• Making them is a goal, not required (“real world”)
"Yes, but what are your goals?"
GPM Goals

• “Getting a life” (partnership and social role) is a required goal!
• Making them is a goal, not required (“real world”)
• Guided by feasibility (short term, simple)
• Differences need not be challenged (e.g., cutting, getting a job)
ANTICIPATE CHALLENGES
(establish a non-reactive, reflective mode)

• Common difficulties (e.g., anger, aloneness) are expected

• Increase awareness about hypersensitivity to aloneness, rejection, diminished support

• Safety planning
AVAILABILITY VIDEO
Illustrating …

• Tentative availability ("if needed")
• Repeated calls can be a nuisance/irritating
• Convert into a discussion about intolerance of aloneness ("This is a common problem …")
• It isn’t personal ("You don’t want your safety to depend on the likes of me")
Algorithm for Intersession Availability

("call me if needed")

No calls
~ 30%

OK

Crisis

"Why not call?"
Alternative plan

OK

~ 55%

Repeated Calls (non-crisis)
~ 15%

In next session:
- "was it useful? If so, why?" (aloneness, care, etc.)
- "did you wonder how I (the clinician) felt about being called"
- "might it be managed otherwise?"

Change content of calls
a) abbreviate
b) problem solve
c) email

Change "rules"
a) only for crises
b) call before, not after
c) use ER or emails

Set limit

Set limit
COMMON PROBLEMS

• Refusal to accept the framework
• Patient doesn’t “connect”
• Treater dislikes patient
• Patient won’t leave a dysfunctional relationship with prior treater
SHORT TERM (10 SESSIONS) EFFECTS

• Pre-post effect size & p-value
  ● Total 0.59 (p < .01)
  ● Symptoms 0.63 (p < .01)
  ● Interpersonal 0.48 (p < .01)
  ● Social role 0.23 (p < .05)

• Working alliance improves dramatically
• Effects interpreted to reflect “remoralization”

Kramer et al. J Psychother Psychosom 2014
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Section 6: Case Discussion
Case Discussion – [To be added]

1 = Yes -- will be helpful
2 = Maybe -- possibly helpful with continuing reservations
3 = No -- either not helpful -- or even harmful
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Section 7: Managing Suicidality
“Suicidality and self-endangering behaviors are usually reactions to interpersonal stress; i.e. the perception of rejection and the fear of being alone. “I can help you to manage these behaviors, but to diminish their cause we need to help you find better social supports – people to help you with those situations.”
BPD’S “BEHAVIORAL SPECIALTY”: SUICIDALITY & SELF-HARM

• The risk of suicide is significant – estimates vary from 3% to 10%
  - this rate is particularly high within the young female demographic (~ 33% of youth suicide)

• About 75% self-harm; amongst these, 90% do so repeatedly
  - self-harm increases the risk of suicide 15 to 30 times

• Suicidal acts are ambivalent: *If rescued, I want to live. If not, I prefer to die.*
  - the average number of suicide attempts is 3
  - suicide occurs once per 23 attempts

HELLO SUICIDE HOTLINE? I'VE CHANGED MY MIND!

THE CELLULAR PHONE
1. Assess risk – differentiate nonlethal from true suicide intention
Acute exacerbation of risk

- Major depr’n
- Subst abuse
- At discharge
- Neg Interp events

Crisis Skills
- Low Dose antipsychotics
- Hospitalization
- Problem solve alternatives

Level of risk in BPD

Level of risk in general population

Time course

Acute-on-Chronic Suicide Risk in Patient with Borderline Personality Disorder
ALGORITHM FOR SELECTING LEVEL OF CARE IN RESPONSE TO SELF-ENDANGERING BEHAVIORS

Assess Risk

Suicidal
- Not Dangerous: OP
- Dangerous: Hospital or Residential

Non-Suicidal
- Dangerous: Recurrent, Residential or IOP
- Infrequent: IOP or OP
- Not Dangerous: OP

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
USES OF HOSPITALIZATION

- Safe asylum
- Evaluate treatment and consider changes (This is a failure)
- Assess and address situational stressors (family, work, etc)
- Develop stepdown (aftercare) plans
In the absence of intermediate levels of care, hospitalization should be used when self-endangering behaviors (to either the person’s health or well-being) are judged to be dangerous.
MANAGING SAFETY: EIGHT BASIC PRINCIPLES

1. Assess risk – differentiate nonlethal from true suicide intention
2. Don’t ignore or derogate – express concern
“I’m willing to hospitalize you despite my concern that it will not be helpful. I would do this because I fear you will become more suicidal if I do not. Am I right about that? We would both be better if we could find an alternative, yes?”
MANAGING SAFETY: EIGHT BASIC PRINCIPLES

1. Assess risk – differentiate nonlethal from true suicide intention
2. Don’t ignore or derogate – express concern
3. Ask what the patient thinks could help – foster sense of “self agency”.
"We're encouraging people to become involved in their own rescue."
MANAGING SAFETY: EIGHT BASIC PRINCIPLES

1. Assess risk – differentiate nonlethal from true suicide intention
2. Don’t ignore or derogate – express concern
3. Ask what the patient thinks could help – foster sense of “self agency”.
4. Clarify precipitants (chain analysis) – assume interpersonal stressors.
5. Be clear about your limits; i.e., not being omniscient or omnipotent.
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5. Be clear about your limits; i.e., not being omniscient or omnipotent.
6. Explore the meaning vis-à-vis the therapy; i.e., the therapy’s effectiveness, the alliance with the therapist.
CONTRACTING FOR SAFETY:
(A signed statement that a patient will not engage in self-destructive behaviors)

• Can’t replace risk assessment: e.g., competence, impulsivity, and motivation

• Depends on good alliance (patient shares objections): otherwise externalizes safety conflict

• Can sometimes undermine alliance:
  - reliance on spoken words and inner controls
  - indicates therapists’ insecurity and concern for liability
MANAGING SAFETY: EIGHT BASIC PRINCIPLES

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6. Explore the meaning vis-à-vis the therapy; i.e., the therapy’s effectiveness, the alliance with the therapist.
7. Develop safety plan.
8. Discuss with colleagues – consultation or supervision (“don’t worry alone”).
SAFETY VIDEO
Illustrating …

• Engaging the patient as an active collaborator
• Identifying the interpersonal stressor
• Anticipating recurrences – encouraging self awareness (“think first”)
• Involving others in creating a safety net
GUIDELINES TO MANAGING SAFETY: DURING CRISSES

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 (specifically, interpersonal, e.g., rejection or loss of support, e.g., step-down).
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.

From GPM Handbook, Gunderson & Links, 2014
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. **Discuss** the interpersonal stressor (aloneness, rejection, step-down, etc.).
3. **Actively interpret** the non-specific reasons that can and did provide relief, i.e., the experience or perception of being cared for (“held”).
4. **Identify** the unfeasibility of depending upon your availability
5. **Problem solve** about available alternatives.
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Section 8: Case Discussion
Case Discussion – Laura

1 = Yes -- will be helpful
2 = Maybe -- possibly helpful with continuing reservations
3 = No -- either not helpful -- or even harmful
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Section 9: Pharmacotherapy & Comorbidity
“I’d like you to try this medication knowing that whether it will help is not certain and that 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 affect. Will you do this?”
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 for BPD.
- Pharma-sponsored research has been limited by fears of violent or suicidal acts and associated liability (pschiatry’s message).
- Polypharmacy (~ 30%) is associated with multiple side-effects and with poorly structured “split” Txs. No evidence supports augmentation.
- The number of medications is inversely related to improvement.
- Medication effects on interpersonal relationships (BPD’s core) is unexamined.
Alliance Building When Managing Medications for 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 an empirical process in which you learn together whether, and what, medications can help.

4) Stress the necessity for responsible usage to evaluate effectiveness.
MEDICATION VIDEO
Illustrating …

• Irreverent exchanges that evolve after long-standing therapies
• Pragmatic bargaining to sidestep resistance to changing medications
• Integrating med management with therapy
• Retaining focus on relationships and work
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” (e.g., 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

**Assess**

- **Mild symptoms**
  - No request
    - No meds
  - Requests
    - **Affective**
      - MS
      - AD
    - **Impulse/Anger**
      - AP or MS
      - Change Class
        - MS ↔ AP
  - **Cogn/Perc**
    - Atypical AP
    - Change Type
      - AP

MS = mood stabilizer
AP = antipsychotic
AD = antidepressant
## Symptom targets and 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>Selective serotonin reuptake inhibitors</strong></td>
<td>?</td>
<td>+</td>
<td>?</td>
<td>?</td>
<td>+</td>
<td>-</td>
</tr>
<tr>
<td><strong>Tricyclic Antidepressants</strong></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>+</td>
<td>?</td>
<td>-</td>
</tr>
<tr>
<td><strong>Mood stabilizers</strong></td>
<td>+</td>
<td>?/+</td>
<td>?</td>
<td>++</td>
<td>++</td>
<td>-</td>
</tr>
<tr>
<td><strong>Antipsychotics</strong></td>
<td>+</td>
<td>?</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>++</td>
</tr>
<tr>
<td><strong>Anxiolytics</strong></td>
<td>?</td>
<td>-</td>
<td>?</td>
<td>-</td>
<td>-</td>
<td>?</td>
</tr>
</tbody>
</table>

**Note.**  ++ = helpful; + = modestly helpful; ? = uncertain, - = negative

**Source.** Adapted from Mercer et al. 2009; Silk and Faurino 2012
Summary:

• Benzodiazepines: habit forming, sometimes disinhibiting. Relatively contraindicated

• Mood Stabilizers: the type of medication with broadest effectiveness. Little effectiveness for depression or stabilizing mood; more for anger/impulsivity.

• Antipsychotics: the 2nd broadest effectiveness. Side effects encourage time-limited trials
### INTERACTIONS OF BPD WITH AXIS I

<table>
<thead>
<tr>
<th>Effect</th>
<th>Co-Occurring Axis I Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MDD</td>
</tr>
<tr>
<td>↓ BPD</td>
<td>MAYBE</td>
</tr>
<tr>
<td>↓ Axis I</td>
<td>YES</td>
</tr>
</tbody>
</table>

Gunderson & Links, 2014
## BPD COMORBIDITY: 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></td>
<td></td>
</tr>
<tr>
<td>manic</td>
<td>No</td>
<td>Unable to use BPD therapy</td>
</tr>
<tr>
<td>not manic</td>
<td>Yes</td>
<td>Recurrence ↓ if BPD remits</td>
</tr>
<tr>
<td>bipolar II</td>
<td>?</td>
<td>More research needed</td>
</tr>
<tr>
<td>Panic disorder</td>
<td>Yes</td>
<td>Will remit if BPD does</td>
</tr>
<tr>
<td>PTSD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>early onset (complex)</td>
<td>No</td>
<td>Too vigilant to attach/be challenged</td>
</tr>
<tr>
<td>adult onset</td>
<td>Yes</td>
<td>BPD predisposes to onset, 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>dependency</td>
<td></td>
<td>sustained sobriety required</td>
</tr>
<tr>
<td>abuse</td>
<td>No</td>
<td>concurrent tx required</td>
</tr>
<tr>
<td>Probably</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antisocial PD</td>
<td>?</td>
<td>Is there 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></td>
</tr>
<tr>
<td>anorexia</td>
<td>No</td>
<td>Unable to use BPD treatment</td>
</tr>
<tr>
<td>bulimia</td>
<td>?</td>
<td>Is physical health stable?</td>
</tr>
</tbody>
</table>
COMORBID ANXIETY

- BPD stress-sensitive, frequently anxious
- Psychoeducation (e.g., interpersonal sources, good prognosis) helps anxiety management
- Meds secondary but helpful
  - Mood stabilizers likely primary, perhaps SSRIs
  - PRN anxiolytics hazardous; preferably integrated with self-assessment or diary card
  - Benzodiazepines have limited role
COMORBID SUBSTANCE USE DISORDERS

With dependency: sobriety of 30-60 days required, 6 months preferable

With abuse: support sobriety, 12-step programs, integrate into therapy
Good Psychiatric Management

Section 10: Multimodel Treatments
SPLIT TREATMENT ADVANTAGES
(Split means ≥ 2 treaters/modalities)

- Better compliance with medications
- Fewer dropouts
- Less suicide threats and self-injurious behaviors
- Less burden on treaters
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 TREATER’S VILLIFICATION

• URGE THAT THE COMPLAINTS BE VOICED TO THE OTHER (This is a corrective experience)
“Group therapies will show you that others have similar problems and have different ways of coping with them. They will also highlight how you impede making the close partnerships that you want, and they can help you change those patterns. Moreover, in group therapies you can learn to listen when people express feelings you usually avoid and you can learn to understand why people have those feelings.”
WHAT GROUPS ADD

• Social skills (listening, sharing, competing)
• Self-disclosure (↓ shame, isolation)
• Assertiveness (self-respect, self-care)
• Self-other awareness (mentalizing)
• Alternative objects
• Support
TYPES OF 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*)
FAMILY PSYCHOEDUCATION

• BPD is a problem within the person and in relation to others; not simply a symptom of a problem family.
• “Bad” parents are mainly uninformed or ill, not malevolent.
• Family support is often needed for treatment! This requires their being informed about etiology, therapy, prognosis, and course.
• Psychoeducation can diminish harmful anger, criticism.
• Families bear a heavy burden: alienation and social isolation.
• Better management strategies can reduce family burden and alienation
FAMILY GUIDELINES

Multiple Family Group Program
at
McLean Hospital

by

John G. Gunderson, M.D.
and
Cynthia Berkowitz, M.D.

Published by
The New England Personality Disorder Association
(617) 855-2680
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.

From Berkowitz & Gunderson, PE/MFG Manual for BPD
FAMILY MANAGEMENT VIDEO
Illustrating …

• Setting limits on angry ventilation
• Seeing the parents separately from the BPD offspring
• Helping parents revise their roles and “discuss first” before responding
• Helping the BPD child see the advantages of getting parents involved
• Psychoeducation
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 groups, “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 – reserved for patients and parents who 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.
Good Psychiatric Management

Section 11: Termination
TERMINATION I: The Ideal

- time dedicated to this
- review of experience – especially (-) (Freud’s formulation of “Mourning & Melancholia”)
- no further contact (health complete, resilience and independence attained, and separation permanent)
TERMINATION II: Sampling

• $N \approx 30$ patients seen $>2x$ week for $>3$ months
• mean $\sim 1.5 - 2$ years
• sampling based by my recall/level of involvement (neither systematic nor complete)
TERMINATION III: Personality types

- Most patients were BPD (N = 16) or NPD without BPD traits (N = 12)
- BPD patients have been far more likely to keep in touch and/or return for visits than have NPD patients
- BPD patients frequently drop out (i.e., 35 – 60%)
<table>
<thead>
<tr>
<th>Study</th>
<th>Type Therapy</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skodol et al. '83</td>
<td>Generic OPC</td>
<td>67% by 3 mo</td>
</tr>
<tr>
<td>Gunderson et al. '84</td>
<td>Generic OPC</td>
<td>43% by 6 mo</td>
</tr>
<tr>
<td>Waldinger &amp; Gunderson '84</td>
<td>Private practice by experts</td>
<td>46% by 6 mo</td>
</tr>
<tr>
<td>Yeomans et al. '93</td>
<td>transference focused</td>
<td>30% by 2 mo; 64% by 12 mo</td>
</tr>
<tr>
<td>Stevenson &amp; Meares '92</td>
<td>Relational (ala Kohut/Adler)</td>
<td>17% by 12 mo</td>
</tr>
<tr>
<td>Linehan</td>
<td>DBT</td>
<td>17% by 12 mo.</td>
</tr>
<tr>
<td>Bateman &amp; Fonagy</td>
<td>MBT</td>
<td>17% by 18 mo.</td>
</tr>
</tbody>
</table>
TERMINATION IV: Outcomes

• All patients stabilized; i.e. became symptomatically better
• Two patients had what, in retrospect, can be considered “pseudotherapies” or “non-therapy therapies”
• Half achieved substantive personality/functional improvement
• Most get better, none are “healthy”
TERMINATION V: Process

- Patient and I agreed that termination made sense – that sufficient improvement was achieved ~ 50%
- This was highly correlated with my impression that changes had exceeded stabilization, i.e., involved personal change
- Termination was often precipitated by situational changes
  - relocation (school, work, family) ~ 40%
  - new partners/replacements ~ 15%
- Idealized and/or transitional object transferences represent a relatedness style that lends itself to patients finding other partners to replace you
TERMINATION VI: Unilateral Terminations

• **Unilateral terminations**
  - by me (N = 2)
  - by patients (i.e., dropouts) (N = 5)

• Are dropouts “negative therapeutic reactions”?

• Being “left” by patients evoked more feelings in me than leaving had on them
Negative Therapeutic Reactions

• unconscious guilt – masochism, unconscious envy
• destroy the therapist’s offerings; destroy the therapist as a good object
• unconscious identification with a bad (sadistic) object

TERMINATION VII: Impressions

• Some leave with mourning (sadness and appreciation)
• Most leave with anxieties that require assurances of ongoing availability
• Abandonment fears diminish during treatment before intolerance of aloneness
• Internalization of a soothing other takes
TERMINATION VIII: Conclusions

• Completing a “piece of work” is a desirable paradigm
• Mourning is not a reasonable expectation for many patients
• Resilience improves, but the support/adversity of life events/environment usually override the effects of psychotherapy
Good Psychiatric Management

Section 12: Conclusions & Q&A
TERMINATION: Impressions

• Few leave with mourning (sadness and appreciation)
• Most leave with anxieties that require assurances of ongoing availability
• Abandonment fears diminish before intolerance of aloneness
• Internalization of a soothing other takes years
WHY DOES THIS WORK?

• Pride in skills ("If you can treat borderline patients, you can treat anyone")
• Personal growth
• Having a highly personal, deeply appreciated, life-changing role