Psychotherapy for
Borderline Personality Disorder

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Goals

- Gain familiarity with the evidence-based treatments for BPD, including theory, research, and practice
- Learn a model of BPD to inform treatment
- Apply common treatment principles into existing practices

Financial Disclosures/ Conflicts of Interest: None
Prevalence of Borderline PD

- 1-2% point prevalence and 6% lifetime prevalence
- 10% of psychiatric outpatients and 20% of psychiatric inpatients
- 10% of outpatient drug & alcohol rehabilitation centers and 20% of inpatients
Functional Impairment of Borderline Personality Disorder

Axis V (GAFS) Ratings Over 2 Years

Skodol et al: *Psychol Med*, 2005
Substantial Research Support

• **Cognitive Behavioral:**
  - Dialectical Behavior Therapy
  - Schema Therapy

• **Psychodynamic:**
  - Dynamic Deconstructive Psychotherapy
  - Mentalization-Based Treatment
  - Transference Focused Psychotherapy

• **Medications:**
  - Low dose antipsychotic or mood stabilizers
  - Avoid benzodiazepines
Included in SAMHSA's National Registry of Evidence-based Programs and Practices
Cognitive Behavior Therapy

- Modify core beliefs/attributions about self and other
- Reduce maladaptive behaviors
- Learn new behavioral strategies
CBT Research: BOSCOT Trial

(Davidson et al., 2006)

• N = 106, U.K.
• Randomized to CBT versus TAU
• 12 mos (30 sessions CBT) with 24 mos f/u
• No differences between treatments on any measure at 12 months
• No differences between treatments on most measures at 24 months
Transference Focused Psychotherapy: Object Relations Theory

Self

Affects

Other

Childhood Experiences
Split Organization:
TFP Practice

- Explicit treatment expectations
- Two individual sessions per week
- No pre-set duration of treatment. No group
- Interprets the here-and-now interactions between patient and therapist
- Integrate polarized object relations
TFP Research
(Clarkin et al., 2007)

Study 1

- N=90
- 12 months of TFP vs. DBT vs. Supportive
- No follow-up period
- No significant differences between groups
- Only TFP changed attachment status from insecure to secure (Levy et al. 2006)
Study 2

- N=104
- 12 months of TFP vs. “community experts”
- No follow-up period
- TFP significantly better all outcomes
Mentalization Based Treatment

- We have to understand that we have
  - SEPARATE MINDS that (often) contain
  - DIFFERENT MENTAL MODELS of reality

- We have to be able to infer and represent
  - the MENTAL MODELS of the other’s MIND and
  - the MENTAL MODELS of our own MIND
MBT: Practice

- Explicit treatment expectations
- Focus mainly on recent relationships and patient-therapist relationship
- Weekly individual + group
- Explore and challenge mentalized attributions/beliefs of self and other
- Help patient feel responded to and understood
MBT Research:
Study 1: partial hospitalization (*Bateman & Fonagy 2008*)

- N=41, MBT in partial hospital (individual + group) vs TAU (minimal community care)
- 18 months MBT/PH, then 8-year naturalistic follow-up
- MBT/PH did much better across all outcomes
- Improvement continued during follow-up
MBT Research

Study 2: outpatient (Bateman & Fonagy 2009)

- N=134, MBT (individual + group) vs Supportive (individual + group)
- 18 months treatment with no follow-up
- MBT did better across all outcomes
Dialectical Behavior Therapy: Theory

– Borderline Personality Disorder is a disorder of emotion dysregulation
– Emotion dysregulation results from a “skills deficit”, i.e. not knowing effective skills or how to use them to regulate emotions
DBT: Practice

- Explicit treatment expectations
- Weekly individual and group psychotherapy
- Teach and practice 4 skill sets: mindfulness, emotion regulation, distress tolerance, interpersonal effectiveness
- Validation and coaching
DBT Research

1. N=44. DBT > TAU for self-harm, but not depression at 12 mo, and not self-harm at 24-mo follow-up (Linehan 1991, 1993)

2. N=58. DBT > TAU for self-harm, ETOH & drugs at 12 months, but after 6 mo f/u ETOH and drugs returned to baseline (Verheul 2003, van den Bosch 2002, 2005)

3. N=101. 12 mo + 12 mo f/u. DBT > “community expert” for suicide attempts, but not self-harm or depression (Linehan 2006)

4. N=90. 12 mo DBT=TFP=Supportive (Clarkin 2007)

5. N=180. 12 mo + 2 yr f/u. DBT=Supportive (McMain 2012)
Dynamic Deconstructive Psychotherapy:

*Helps clients connect to themselves and to others*

Theory: **two core problems:**

1. Aberrant neural pathways for emotion processing
2. Embedded sense of badness
Dynamic Deconstructive Psychotherapy

Practice:
• explicit treatment expectations
• manual (www.upstate.edu/ddp)
• weekly individual (no required group component)
• limited duration (12 months)
• 3 sets of techniques:
  - Association
  - Attribution
  - Alterity
DDP is not DBT

• The therapist does not give advice
• The therapist generally does not initiate topics
• The therapist does not help patient solve problems
• The therapist does not teach the patient new coping skills
• The therapist does not provide validation
DDP Research: Study 1

12-Month RCT with 30-Month Follow-Up

* Gregory et al., Psychotherapy, 2008
  Gregory et al., JNMD, 2010

- N=30, BPD and alcohol use disorder
- 12 months DDP vs. optimized community care
- DDP therapists mostly psychiatry residents
- Multiple comorbidities (antisocial PD – 43%, illicit drug use – 83%, bipolar disorder – 17%)
Depression Severity (Beck Depression Inventory)

* p = .012
% Heavy Drinking Days

Baseline | Active Treatment | F/U

Pre-entry | 6 months | 12 months | 30 months

- ** p = .043
- * p = .066
% Days Using Recreational Drugs

- Pre-entry
- 6 months
- 12 months
- 30 months

Baseline  Active Treatment  F/U

* p = .001
What is the response rate to a year of treatment?

(Gregory et al., J Nerv Ment Dis, 2010)

* p = .005
odds ratio = 16
12 month naturalistic outcomes of 68 clients in Upstate’s BPD program
3 different treatments:
– DBT comprehensive
– DBT skills + eclectic therapy
– DDP
BPD symptoms

*DDP vs. DBT: $p = .042$, $d = .53$
Beck Depression Inventory (ITT analysis)

*DDP vs. DBT: $p = .009, d = .63$
What is the response rate to a year of treatment?
Borderline Personality Disorder

Theory: **two core problems:**

1. Aberrant neural pathways
2. Embedded badness
Aberrant processing of emotional experiences

- Hippocampus
- Medial pf cortex
- Anterior cingulate gyrus
- Amygdala (PANIC)
- Ventral Striatum (SEEKING)
Cortical Deactivation

• Recalling specific emotional social interactions: vmPFC, hippocampus, insula, and vlPFC (Buccino et al., 2004; Nelissen et al., 2005)

• Realistic attributions/representations of self and others. Cognitive empathy, theory of mind, and self/other differentiation: vmPFC, PCC, TPJ (Koenigs & Tranel, 2007; Mitchell et al., 2005; Shamay-Tsoory et al., 2005)
Unmodulated Subcortical Activation

- Amygdala mediates **PANIC**, irritability, and separation distress (*Tragesser 2007*)
- Ventral striatum mediates **SEEKING** impulsive pleasure and/or attachment, which dampens amygdala activity (*Ernst et al. 2005, Koelsch et al. 2007*)
- Video: ed PANIC.wmv  jc SEEKING.wmv
Lieberman et al., Psychological Science, 2007
Amygdala activity in fMRI scan and autonomic arousal
Treatment Implications
(neurotrophic therapy)

• Repeatedly activate cortical pathways for emotion processing (Association technique)
  – Practice recounting recent social interactions and label specific emotions
  – Practice making realistic meanings of those interactions
Embedded Badness

- Depression, suicide, self-harm
- Mood reactivity/ rejection sensitivity
- Splitting/ distorted schema
- False self vs. *individuated relatedness*
Treatment Implications

1. Open up meaning in a narrative by asking about alternative or opposing meanings (*Attribution technique*)

2. Develop individuated relatedness experientially in the patient-therapist relationship (*Alterity technique*)
Commonalities among empirically supported treatments for BPD

- Explicit treatment expectations/boundaries
- Focus on emotions and meanings of recent social interactions
- Experiential component, i.e. patient-therapist relationship can be healing vs. harmful
- Early on, avoid talking about childhood trauma
- On-going consultation recommended to help maintain boundaries and therapeutic stance
Practical Implications

• Employ evidence-based manualized treatments if available, especially TFP, MBT, DBT, or DDP
• Maintain strict boundaries, including explicit treatment expectations and no physical contact
• Focus on recent social interactions or patient-therapist relationship, rather than childhood
• Patient labels specific emotions (not just “anxious”)
• Provide respect and acceptance, without fostering dependency and endless treatment
• Seek on-going consultation
www.upstate.edu/ddp

http://nrepp.samhsa.gov