Disclosure

Relevant Financial Relationships
Harvard Medical School – Online CME course - royalties
Mayo Clinic Board Review Texts – royalties

Off-Label/Investigational Uses
There are no FDA approved medications for BPD, and we will review brief evidence for medication options.
Learning Objectives

• Differentiate BPD from mood disorders based on clinical context, course and outcome, and symptoms

• Articulate principles of treatment, including case management
Personality Disorders

- Cluster A
  - Paranoid, schizoid, schizotypal

- Cluster B
  - Antisocial, borderline, histrionic, narcissistic

- Cluster C
  - Avoidant, dependent, obsessive-compulsive
BPD Criteria

- 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
BPD’s Interpersonal Coherence

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

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

**Alone**
dissociated, paranoid impulsive, help-rejecting

**Desperate**
suicidal, anhedonic

**Interpersonal Stress**

**Support by the other**

**Withdrawal by the other**

**Holding (hospital, jail, rescuer)**

Gunderson 2014
Basic Epidemiology

• Prevalence
  • Roughly ~20% of clinical samples
  • 1.2 - 5.9% of the community samples

• Gender
  • Approximately ~75% female in clinical samples
  • More equal M:F ratio in community samples
Heritability / Familiality

• Across two twin studies, one family study
  • 55% heritability for BPD
  • Single latent factor accounts for the co-occurrence of interpersonal, emotional, behavioral and cognitive components

Gunderson, Arch Gen Psychiatry, 2011; Kendler, Acta Psychiatr Scand, 2011; Distel, Biological Psychiatry, 2009
You’re seeing a depressed patient with BPD. How to prioritize?

1. BPD should not be diagnosed during a depressive episode.
2. Depression tends to stay “treatment resistant” until BPD improves.
3. Treating depression to remission should precede BPD treatment.
4. The depression in BPD is most commonly bipolar depression.
Make the Diagnosis

• 40% of patients who do have BPD and do not have bipolar disorder have previously been *inaccurately* diagnosed with bipolar disorder

• Comorbid depression does not impact the accuracy of BPD assessments
Bipolar Diagnosis Issues

• The diagnoses can co-occur – and do!
  • CLPS (196 BPD patients)
    • 20% with BP (12% BPI, 8% BPII)
    • 8% new BP in 2y (4% BP1, 4% BPII)
  • MSAD (290 BPD patients)
    • 10% baseline BPII
    • 6% new BP in 6y (1% BPI, 5% BPII)

MDQ and MSI BPD screen of 172 pts with BP, BPD, or Both

**BP**
Dec sleep, Inc Energy, Activity, Speech
Confident, Hyper
?Unreal

? (Question Mark)
Moodiness, Arguments, Distractibility, Spending

**BPD**
Self Harm, Anger Problems, Mistrustful in Relationships
?Irritability
Differentiating BPD/Bipolar

Think **interpersonally** for BPD

- Abandonment intolerance and self-injury in reaction to interpersonal context.

Think **syndromally** for BP

- Period of sleep-deprived energy enhancement with increased goal directed activity
What to tell a patient about long-term outcomes?

1. The vast majority (>80%) of BPD patients remit, and relapse is rare
2. BPD remission typically includes work and a stable partnership
3. Few (<30%) BPD patients remit, but relapse is rare when they do
4. Sense of self improves before self-injury
BPD’s Longitudinal Course

*From the Collaborative Longitudinal Study of Pers Disorders (i.e., Gunderson, Archives 2011)
**From the McLean Study of Adult Development (i.e., Zanarini, Am J Psych, 2003)
Outcomes

• After 10 years one third had full-time work.

• BPD has a markedly negative effect on MDD (“treatment resistance”) until BPD remits, but MDD has only modest effects on BPD’s course.

• BPD is most common reason for persistence of depression.

Gunderson Arch Gen Psychiatry 2011; Yoshimatsu and Palmer, Harvard Rev Psychiatry 2014; Skodol Am J Psychiatry 2011
Clinically

• Patients improve, problems persist (work matters)
• Impulsive symptoms decline more rapidly than affective symptoms
• 20% overlap with bipolar. No impact of bipolar on BPD course, modest impact of BPD on bipolar course.
• Think interpersonally for BPD diagnosis and treatment.
Empirically Validated Treatments

- Dialectical Behavioral Therapy (DBT)
  - Linehan et al., 1993, 2006

- Mentalization Based Treatment (MBT)

- Schema Focused Therapy (SFT)
  - Giesen-Bloo et al., 2006

- Transference Focused Psychotherapy (TFP)
  - Clarkin et al., 2007; Levy et al., 2006

- Systems Training for Emotional Predictability & Prob. Solving (STEPPS)
  - Blum et al., 2008

- General Psychiatric Management (GPM)
  - McMain et al., 2009 (after Gunderson & Links)
A Spectrum of Approaches

Cognitive Behavioral

DBT
STEPPS

Psychodynamic

MBT
SFT
TFP
GPM
Dialectical Behavioral Therapy

- Most widely available and studied.
- Skills group, behavioral therapy, skills coaching, consultation team.

- Core dialectic: acceptance AND change

- Skills group most important

Linehan, et. al. JAMA Psychiatry 2015
Mentalization Based Treatment

- Longest study shows gains in symptom reduction over 8 years
- Simple, general approach that does not require detailed knowledge of skills but a general understanding of a mentalizing process
General ("Good") Psychiatric Management

- As effective as DBT
- Features
  - Psychoeducation, interpersonal focus
  - Case management emphasized (work, volunteer)
  - Pragmatic; integration of psychopharm, groups

McMain, Am J Psych, 2009
Effective Clinical Management of BPD

Spring 2017
Los Angeles
John Gunderson, MD
Brian Palmer, MD
Robin Kissell, MD

ce.mayo.edu
Common Features of Effective TX

• Structured (groups and individual work), coherent and stable, not reactive
• Crisis planning
• Supervision for managing countertransference
• Therapists are active
• Monitoring progress and goals
• Making narrative sense of internal experience

• Not common but should be: anchor treatment in life outside treatment
With respect to medications…

1. Benzodiazepines improve overall outcome by reducing anxiety.

2. Atypical antipsychotics are effective for the cognitive/perceptual symptoms of BPD.

3. Mood stabilizers are unhelpful for BPD

4. SSRI’s have superior efficacy to other classes of medications for BPD.
Meds: Key Principles

1) Collaborate to determine goals and set accurate expectations
   - decrease mood lability,
   - normalize sleep,
   - decrease transient psychotic symptoms

2) Measure the effectiveness of the intervention

3) Use a methodical approach to medication trials. Don’t add without subtracting.

4) Be aware of the dynamics.
Reactive Treatment: Perilous

• Persons with BPD often seek treatment REACTIVELY

• Example: Migraine Headaches
  • more medication overuse headaches
  • more unscheduled (acute) office visits
  • lower overall treatment response
## At a Glance

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<th>Mood Stabilizers</th>
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Adapted from Ingenhon, J Clin Psych, 2010
Specific agents best studied

- Mood stabilizers
  - Best studied with most favorable safety profile: lamotrigine (200 mg) and topiramate (200-250 mg)

- Antipsychotics
  - Aripiprazole (15 mg) and olanzapine (2.5-10 mg), quetiapine (150 mg)

- Antidepressants
  - MAOI’s, fluoxetine (more with impulsivity/aggression, esp in males)
  - Benzodiazepines (esp alprazolam) have no role in BPD
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Questions & Discussion