

GENERAL PRACTITIONER'S MANAGEMENT OF BORDERLINE PERSONALITY DISORDER (GPM-GP)

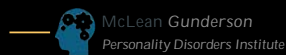
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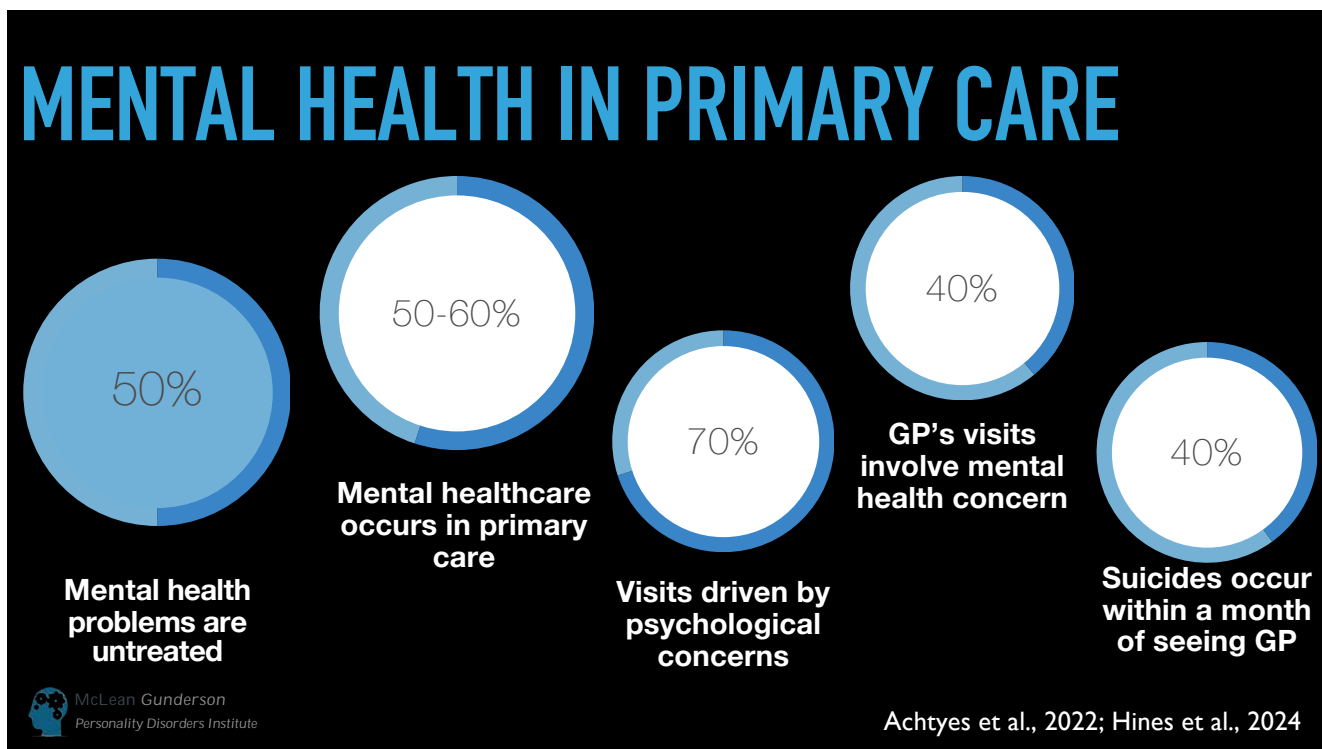
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RELEVANT → CONFLICTS → OF → INTEREST

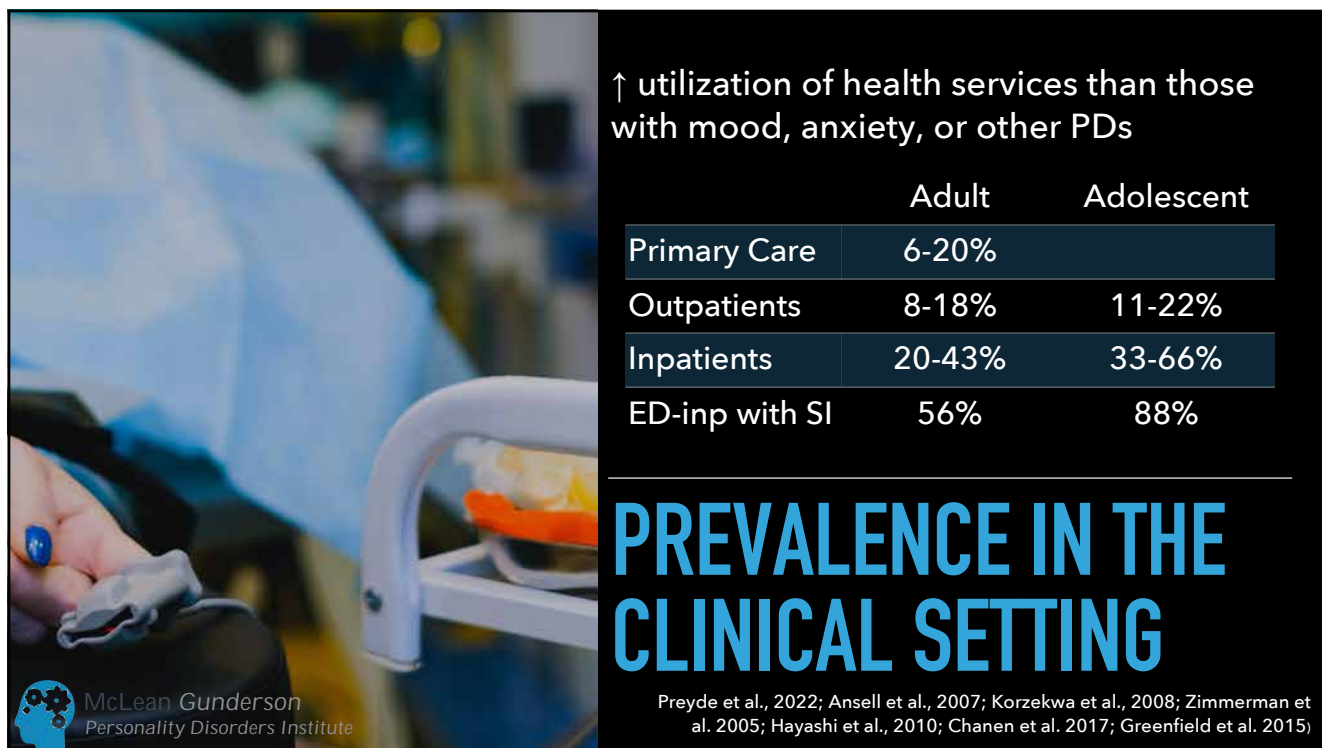
- ▶ American Psychiatric Association Publishing: Royalties for GPM books
- ▶ Tetricus: Consultation
- ▶ Foundational Curriculum Inventor Royalties
- ▶ I will discuss off label use of pharmacology and other brain-based therapeutics because there are no FDA indicated agents for personality disorders



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BPD is 4-6x more common in GP's caseload

- 18.5% to 26% via self-report
- 1/4 depressed patients
- 6% via structured interviews
 - 43% unrecognized by GP to have mental health problems
- 0.017% documented diagnosis

PREVALENCE OF BPD IN PRIMARY CARE

Aragonès et al., 2013; Gross et al., 2002; Hueston et al., 1996; Parsons, 1997; Wiederman & Sanstone, 1998; Riihimaki et al., 2014

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**EVERY GENERAL
PRACTITIONER WILL MANAGE
THE CARE OF PEOPLE WITH
BPD ON A DAILY BASIS**

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**GENERAL PRACTICE IS WHERE
MOST BPD CARE ACTUALLY
HAPPENS**

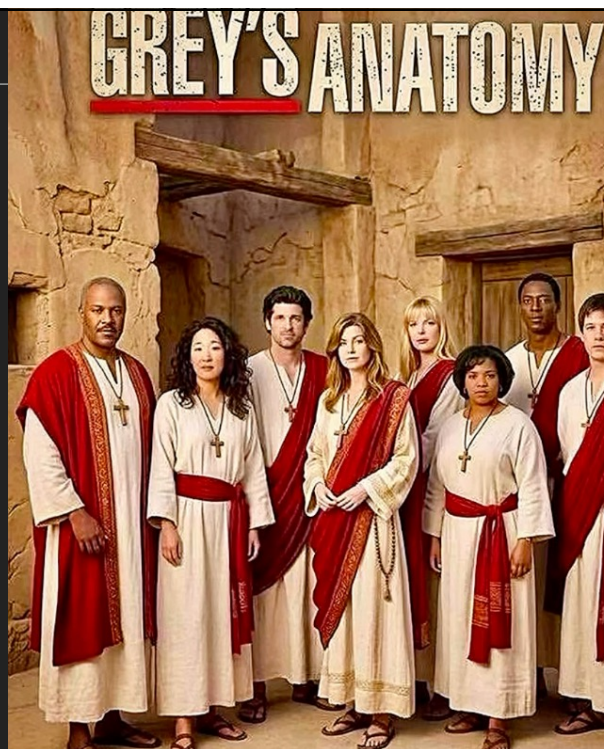
**GENERAL PRACTITIONERS
NEED AND DESERVE GUIDANCE
ON HOW TO OPTIMALLY DO A
GOOD ENOUGH JOB, AS GP'S
(NOT AS SPECIALISTS)**

GPM-GENERAL PRACTITIONERS STOCKHOLM

ARE WE EXPECTING A MIRACLE?

Expecting General Practitioners to adapt psychotherapies for BPD in less time, with less training, and more complex concerns is unrealistic

We are often idealizing what can be done in the best case scenario, at the expense of what can realistically be done, setting up generalists and most clinicians for failure



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We can help them learn about their problems, so they can manage them with support, and learn from life's lessons as a source of therapy



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CLINICAL CHALLENGES

- ▶ **Greater complexity of medical care**
 - ✓ High utilization: consultations, phone calls, and requests for medications (Sansone et al, 2011)
 - ✓ Frequent missed appointments, follow up of laboratory and radiologic studies, and treatment recommendations
- ▶ **Greater complexity of mental healthcare**
 - ✓ Among depressed patients: double the risk for anxiety; 3x risk for SUD, suicidal ideation, 4x prevalence of suicide attempts; severe economic difficulties and unemployment
- ▶ **Greater complexity of practitioner-patient relationship**



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Sansone et al., 2011; El-Gabalawy et al., 2010; Rithimaki et al., 2010



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BPD & PHYSICAL HEALTH

- ▶ National Epidemiologic Survey on Alcohol and Related Conditions (NESARC; n = 34,653)
- ▶ BPD significantly more associated with (adjusted for Axis I disorders and sociodemographics):
 - ✓ Hypertension, hepatic disease, cardiovascular disease, gastrointestinal disease, arthritis, STD, and any assessed medical condition
 - ✓ Greater likelihood of suicide attempts associated with co-morbid cardiovascular disease, STD, and any assessed medical condition
- ▶ GPs may be aware of risk for usual health conditions



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El-Gabalawy et al., 2010



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BPD PREDICTS PHYSICAL HEALTH

BPD traits are associated with:

- ▶ Sleep problems
- ▶ ↑ obesity
- ▶ Chronic conditions/pain, arthritis
- ▶ ↑ physical disability
- ▶ ↑ outpatient and inpatient visits; use of medical services
- ▶ ↓ overall health-related functional status

Chronic BPD pts were more likely than remitted patients to:

- ▶ Chronic medical conditions (obesity, diabetes, hypertension, urinary incontinence, arthritis, chronic pain, multiple medical conditions)
- ▶ suffer from “poorly understood medical syndromes”
- ▶ use expensive forms of medical care (e.g. ER, hospitalization, radiologic studies)
- ▶ make poor lifestyle-related choices (smoking, alcohol, pain/sleeping medications, lack of exercise)
- ▶ quit work/lose job due to ill health

Frankenburg & Zanarini 2004; Keuroghlian et al., 2013); Sansone et al 2001a; Sansone et al 1998; Hueston et al. 1999; Power & Oltmanns, 2013; Cramer et al. 2006, Grant et al. 2008, Jackson et al. 2004

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BPD & CHRONIC STRESS SENSITIVE CONDITIONS

Polycystic Ovary Syndrome

- ▶ In primary care, PCOS is twice as likely in BPD
- ▶ More metabolic complications: obesity, DMII, cardiovascular dz
- ▶ Associated with mood/anxiety
- ▶ Management:
 - Exercise, nutrition
 - Mindfulness-based programs (for stress, anxiety, mood, healthy lifestyle changes)

Postural Orthostatic Tachycardia Syndrome

- ▶ Significantly associated with other psychiatric problems & conditions co-occurring with BPD, e.g., anxiety and mood disorders, sleep problems, CFS
- ▶ Management:
 - Hydration, increasing sodium intake, exercise programs, third-wave CBT
 - **AVOID:** meds that prolong QTc, MAOIs, tricyclics, opiates, quetiapine, ethanol

Migraines

- ▶ BPD => greater migraine severity, associated disability, lower response to usual headache mgt, higher medication overuse, more unscheduled visits
- ▶ Distinct population: more affected and treatment refractory
- ▶ Management:
 - Psychotherapy + medication, treatment contracts with pain control plans
 - Opioids may have adverse effects on BPD symptoms

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BPD & POORLY UNDERSTOOD STRESS SENSITIVE HEALTH CONDITIONS

Fibromyalgia

- ▶ Up to ~9% with BPD have fibromyalgia
- ▶ Negative emotions mediate pain experience
- ▶ History of abuse (physical, sexual, or emotional) increases risk for both dx
- ▶ Management: Exercise, sleep, psychotherapy, mindfulness

Chronic Fatigue

- ▶ ~2-7% also have BPD
- ▶ Psychiatric symptoms may lead to over attribution and coping that perpetuates it
- ▶ History of emotional trauma increases risk of both
- ▶ Management: CBT, graded exercise therapy

Temporomandibular Joint Pain (TMJ)

- ▶ More common in those with BPD, personalities more susceptible to life stress may express anxiety in somatic symptoms
- ▶ Management: CBT, emotion regulation and stress-tolerance skill-building, medications

Greater rates in non-remitted vs. remitted patients



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El-Gabalawy et al., 2010; Frankenburg and Zanarini, 2004; Johnson et al., 2020; Martins et al., 2021; Mu et al., 2024; Penfold et al., 2016; Sáez-Francàs et al., 2015

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THEORIES: BPD & POOR HEALTH OUTCOMES

Chronic BPD pts were more likely than remitted patients to:

- ▶ More likely to have impairing and cumulative damaging health problems with complexity
- ▶ Poorer adherence to treatment and more distress/disability
- ▶ Greater life stress, poor stress management and support system, greater stress generation
- ▶ Hyperbolic temperament leads to amplified pain combined with need for others to recognize it
- ▶ More likely to lack emotionally sustaining relationships; therefore, more likely to seek care from professionals and social services
- ▶ Interpersonal style that leads GPs to order unnecessary tests and prescribe inappropriate treatments to avoid prolonged conflicts

Frankenburg & Zanarini 2004; Keuroghlian et al., 2013); Sansone et al 2001a; Sansone et al 1998; Hueston et al. 1999

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COMPLEX COMORBIDITY

❖ THE RULE RATHER THAN EXCEPTION

- Anxiety disorders most common
- Followed by PTSD which is common but not universal
- Impulse control disorders differ by gender: males with SUD and females with eating disorder
- Complex pattern of co-morbidity predicts BPD with sensitivity

Zanarini et al., (1998) AJP



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ISSUES IN THE PHYSICIAN-PATIENT RELATIONSHIP (PPR)

- ▶ BPD's symptoms of anger, distress and uncertainty intolerance, helplessness/neediness, and self-destructive tendencies make relationships unstable
- ▶ BPD is among the top psychiatric diagnoses associated with poor PPR or difficult patient status
- ▶ Poor self-regulation and direction & dependency on others=> poorer social and health (i.e. pain) related outcomes
- ▶ Fear of abandonment and insecurity in caretaking relationships evoke reliance on actions to demonstrate care or provide reassurance, which disorganizes caregivers who vacillate between helpless and hostile positions
- ▶ Provider discomfort with emotional dynamic and unrealistic expectations
- ▶ GP's receive inadequate pragmatic training to manage BPD

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Bailey, Martin, & Bangs, 2023; Lorenzetti et al., 2013; Huprich et al., 2010



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DOES “DIFFICULT PATIENT” STATUS CONTRIBUTE TO FUNCTIONAL DEMEDICALIZATION OF BPD?

Sandra Sulzer, 2015

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GPM-GENERAL PRACTITIONERS

BPD: MEDICALIZING INTERPERSONAL DIFFICULTIES

- ▶ Psychiatrists were 4x more likely to mention BPD than any other diagnosis related to “difficult patient” status
- ▶ Difficult patients associated with features common in BPD: mutilation, chronic illness, rule breaking, aggression, refusal of care or needing too much care, attention seeking, destructiveness, larger number of problems & intensive service use
- ▶ Demedicalizing: defined not as a medical problem, therefore medical treatments are not the solution
 - ▶ Denial of treatment, perception of manipulation versus illness, discourse of untreatability

Kelly & May, 1982; Nehls 1999; Koekkoek et al., 2006; Sulzer, 2016



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GPM for GPs



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General or Good (enough) Practitioners Management

A preservation of the medical model in treating BPD

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MEDICALIZING TREATMENT FOR BPD

**Roles, goals, & a system of
communication**

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STAY IN YOUR LANE.

**KNOW YOUR ROLE, &
ITS LIMITS. RELY ON
OTHERS AS NEEDED.**

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DO ✓

- Timely and systematic diagnosis BPD
- Verbal treatment contract
- Make referrals when possible
- Monitor and acknowledge your emotions and patient emotions
- Be gentle with yourself and your patient

DON'T ✗

- Casually diagnose BPD
- Expect too much of yourself or the patient
- Become overwhelmed by emotions
- Drop the patient after making referrals
- Rescue the patient from their problems
- Fail to enforce boundaries

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NEW APA GUIDELINES 2024

Recommends initial assessments include BPD diagnosis routinely. Collaborative diagnosis, personalization, and psychoeducation.
Suggest measures such as BSL-23, BEST, ZANBPD

Recommends psychosocial treatment tailored to BPD: Treatment should focus on core features of the disorder including interpersonal/stress sensitivity, emotional dysregulation, identity issues

Suggests psychotropic medication is adjunctive to psychotherapy, and time limited: No evidence for the use of any agent from clinical trials. Medications for co-occurring conditions or targeted symptoms like affect instability, impulsivity, psychosis



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EVIDENCE BASED TREATMENTS FOR BPD

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LIMITED ACCESS

- Demand > Supply
- EBTs are insufficient
- Generalist care improves access

Iliakis et al., 2019



DROPOUT

- 22% across studies
- 28% in RCTS
- 30% adjusting for bias
- Usually in first half of tx

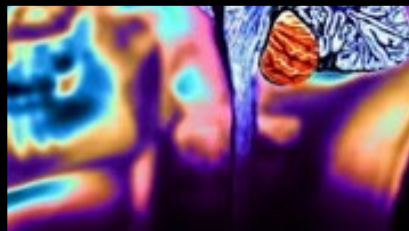
Iliakis, Ilagan and Choi-Kain 2021



NON-RESPONSE

- 28 studies
- 2436 participants
- 48.8% non-response
- No difference in types

Woodbridge et al., 2021



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Research

JAMA | Original Investigation

Effect of Offering Care Management or Online Dialectical Behavior Therapy Skills Training vs Usual Care on Self-harm Among Adult Outpatients With Suicidal Ideation
A Randomized Clinical Trial

Gregory F. Simon, MD, MPH; Susan M. Shrivastava, PhD; Rebecca C. Reason, MD, MS; Anne Beck, PhD; Gregory N. Clarke, PhD; Ursula Whiteade, PhD; Julie E. Richards, MPH, PhD; Robert B. Penhale, PhD; Jennifer M. Buggs, PhD, MDiv; Julia Smith, MS

IMPORTANCE: People at risk of self-harm or suicidal behavior can be accurately identified, but effective prevention will require effective scalable interventions.

OBJECTIVE: To compare 2 low-intensity outreach programs with usual care for prevention of suicidal behavior among outpatients who report recent frequent suicidal thoughts.

DESIGN, SETTING, AND PARTICIPANTS: Pragmatic randomized clinical trial including outpatients reporting frequent suicidal thoughts identified using routine Patient Health Questionnaire depression screening at 4 US integrated health systems. A total of 18 882 patients were randomized between March 2015 and September 2018, and ascertainment of outcomes continued through March 2020.

INTERVENTIONS: Patients were randomized to a care management intervention (n = 6230) that included systematic outreach and care, a skills training intervention (n = 6227) that introduced 4 dialectical behavior therapy skills (mindfulness, mindfulness of current emotion, opposite action, and paced breathing), or usual care (n = 6325). Interventions, lasting up to 12 months, were delivered primarily through electronic health record online messaging and were intended to supplement ongoing mental health care.

MAIN RESULTS AND MEASURES: The primary outcome was time to first nonfatal or fatal self-harm. Nonfatal self-harm was ascertained from health system records, and fatal self-harm was ascertained from state mortality data. Secondary outcomes included more severe self-harm (leading to death or hospitalization) and a broader definition of self-harm (selected injuries and poisonings not originally coded as self-harm).


RESULTS: A total of 18 644 patients (98.6%) aged 45 years or older, 12 543 (67.3%) female, 9222 (50%) from mental health specialty clinics and the remainder from primary care) contributed at least 1 day of follow-up data and were included in analyses. Thirty-one percent of participants offered care management and 39% offered skills training actively engaged in intervention programs. A total of 540 participants had a self-harm event (including 45 deaths attributed to self-harm and 495 nonfatal self-harm events) over 18 months following randomization: 172 (3.2%) in care management, 206 (3.9%) in skills training, and 162 (3.2%) in usual care. Risk of fatal or nonfatal self-harm over 18 months did not differ significantly between the care management and usual care groups (hazard ratio [HR], 1.07; 95% CI, 0.84-1.37) but was significantly higher in the skills training group than in usual care (HR, 1.29; 95% CI, 1.02-1.64). For severe self-harm, care management vs usual care had an HR of 1.03 (95% CI, 0.71-1.50); skills training vs usual care had an HR of 1.34 (95% CI, 0.94-1.91). For the broader self-harm definition, care management vs usual care had an HR of 1.10 (95% CI, 0.92-1.33); skills training vs usual care had an HR of 1.17 (95% CI, 0.97-1.41).

CONCLUSIONS AND RELEVANCE: Among adult outpatients with frequent suicidal ideation, offering care management did not significantly reduce risk of self-harm, and offering brief dialectical behavior therapy skills training significantly increased risk of self-harm, compared with usual care. These findings do not support implementation of the programs tested in this study.

Visual Abstract
Editorial page 636
Supplemental content

A LITTLE DOES NOT GO A LONG WAY

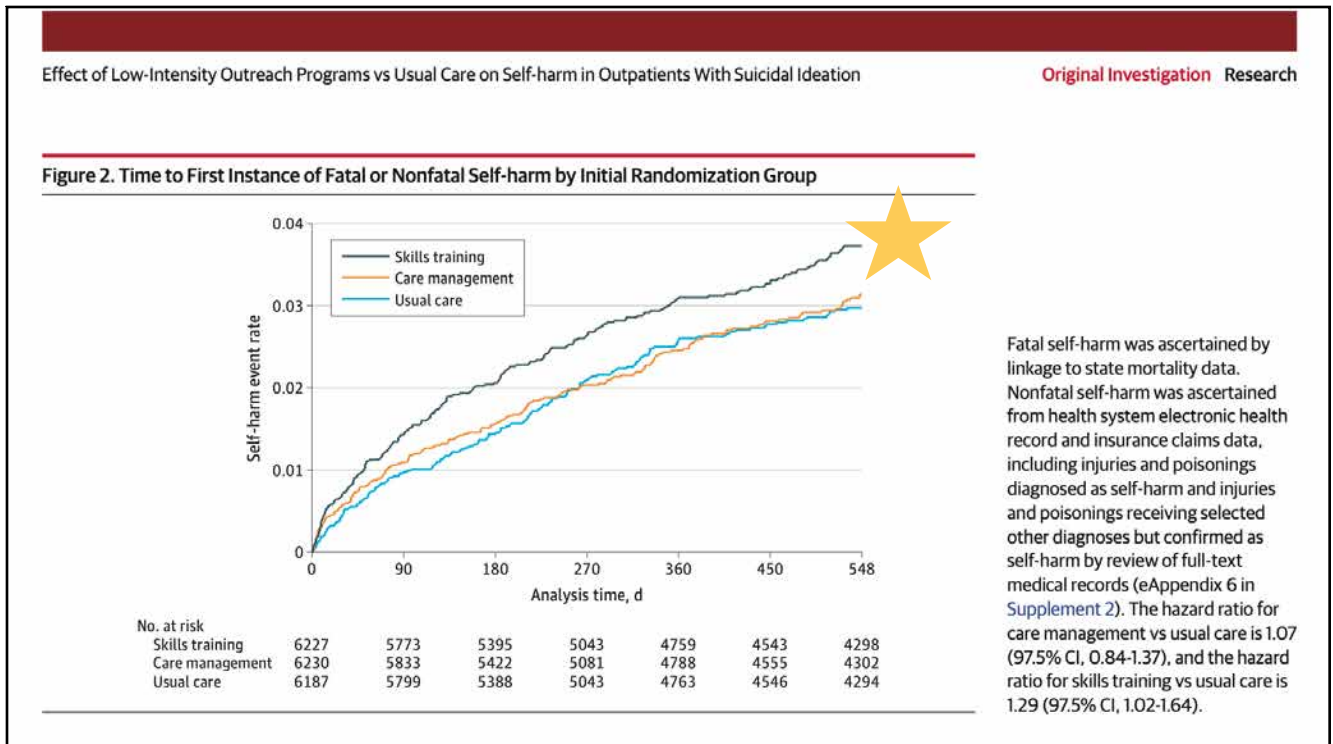
- ▶ Randomized controlled trial of online care (n=18,882 adults with frequent suicidal ideation in 4 healthcare systems) comparing:
 - ▶ management modeled after collaborative care
 - ▶ DBT skills training
 - ▶ Mindfulness, mindfulness to current emotion, paced breathing, opposite action
 - ▶ TAU across four US integrated health systems
- ▶ Neither add on empirically supported suicide reduction intervention (care mgt or DBT) significantly reduced self-harm.
- ▶ Light DBT skills training significantly increased self-harm rates.



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Simon et al 2022

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GENERALIST TREATMENT FOR BPD

NO DIFFERENCE FOR ALMOST ANY OUTCOME BETWEEN SPECIALIST APPROACHES AND MANUALIZED GENERALIST ONE GPM, SCM...

LOW CERTAINTY OF EVIDENCE SINCE HEAD TO HEAD COMPARISONS INVOLVED ONLY SINGLE STUDIES

“OUR FINDINGS SUGGEST THAT GENERALIZED PSYCHOTHERAPIES MAY BE AS EFFECTIVE AS INTENSIVE SPECIALIZED BPD TREATMENTS”

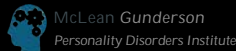
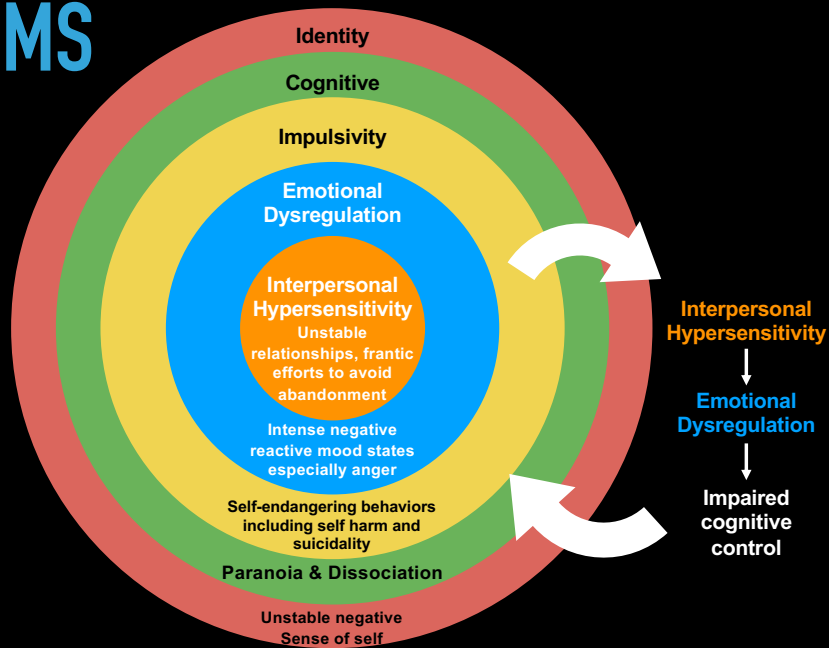
“IN CLINICAL PRACTICE, PATIENTS WITH BPD ARE OFTEN TREATED WITH MEDICATION ALONE OR IN CONJUNCTION WITH THERAPY.”



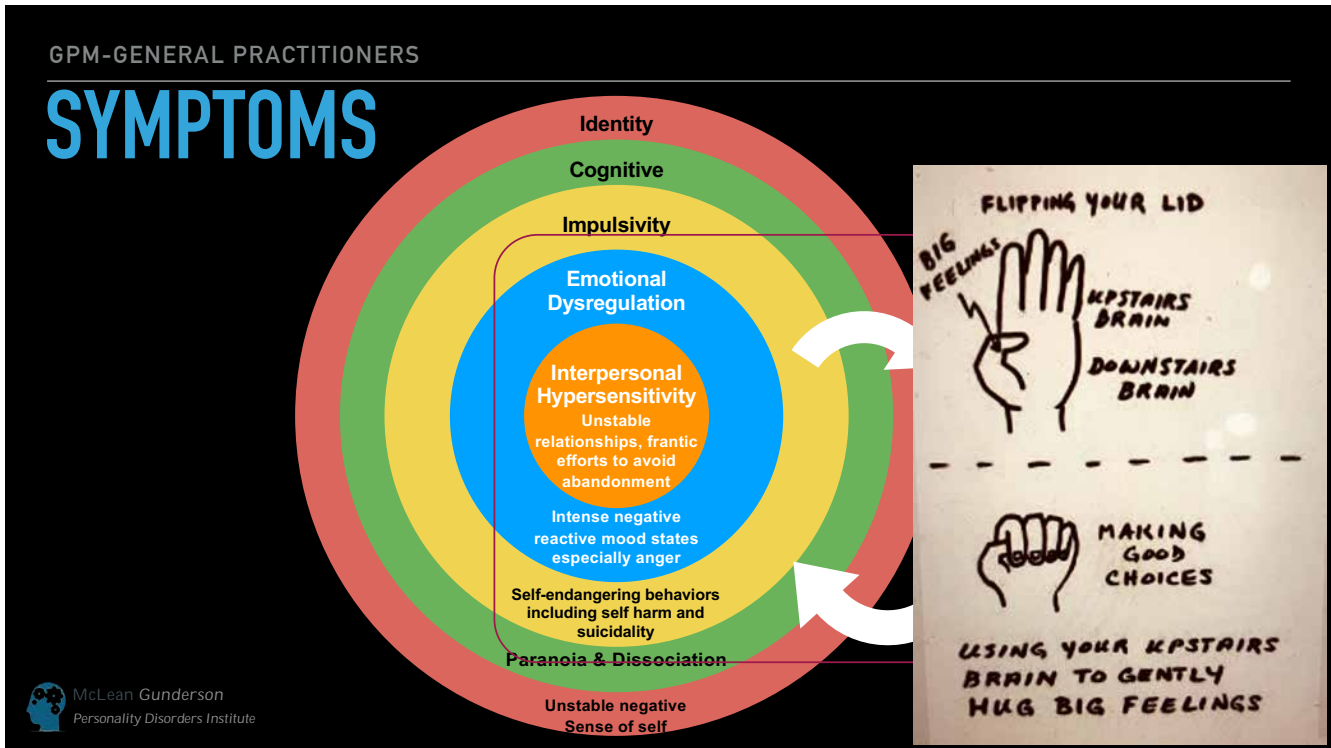
Crotty et al., 2024 J Consulting and Clinical Psychology

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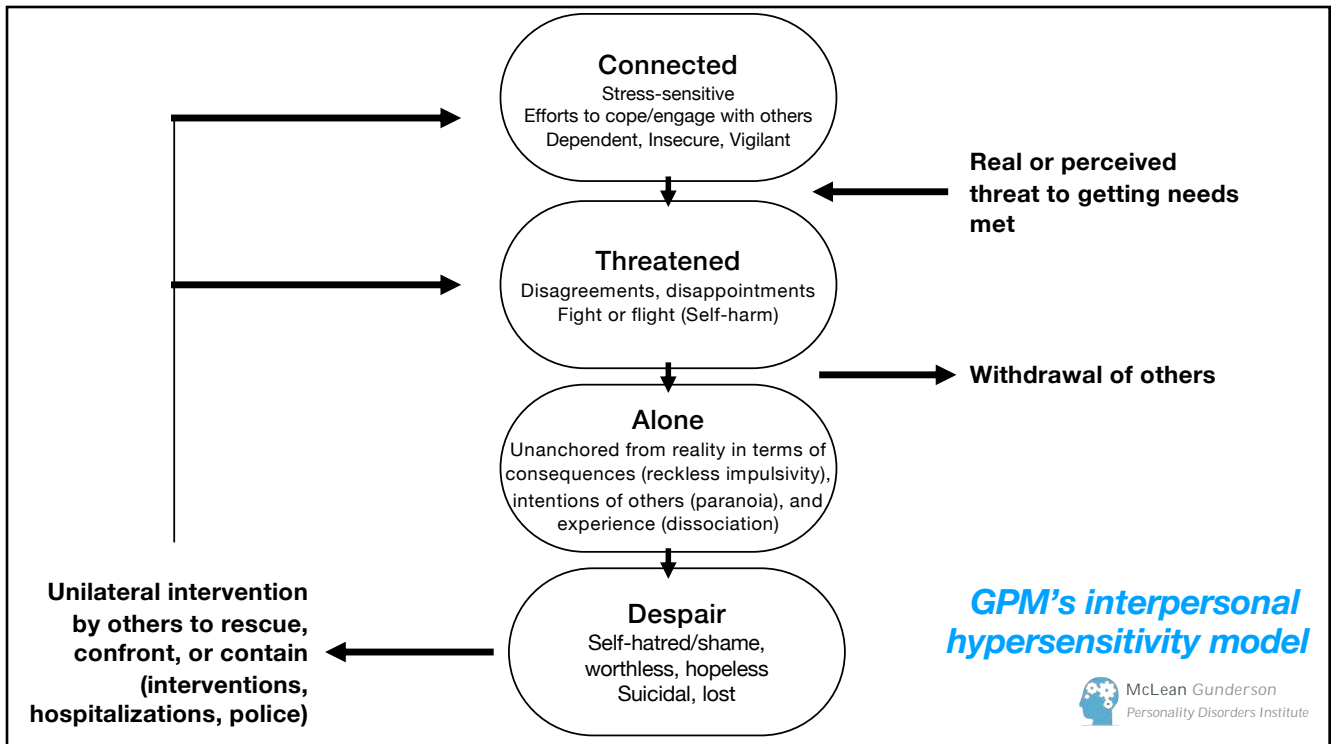
SYMPTOMS



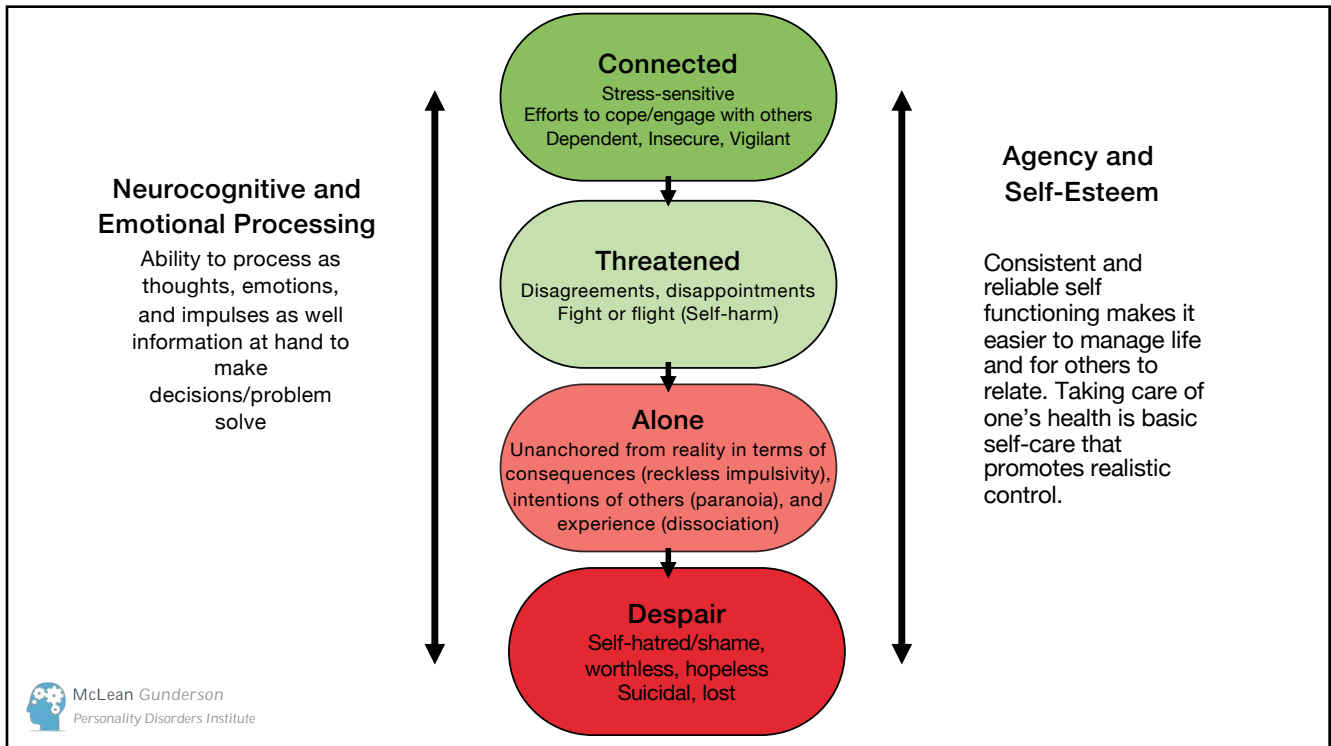
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GPM-GPS

STRESS REACTIVITY AND STRESS GENERATION

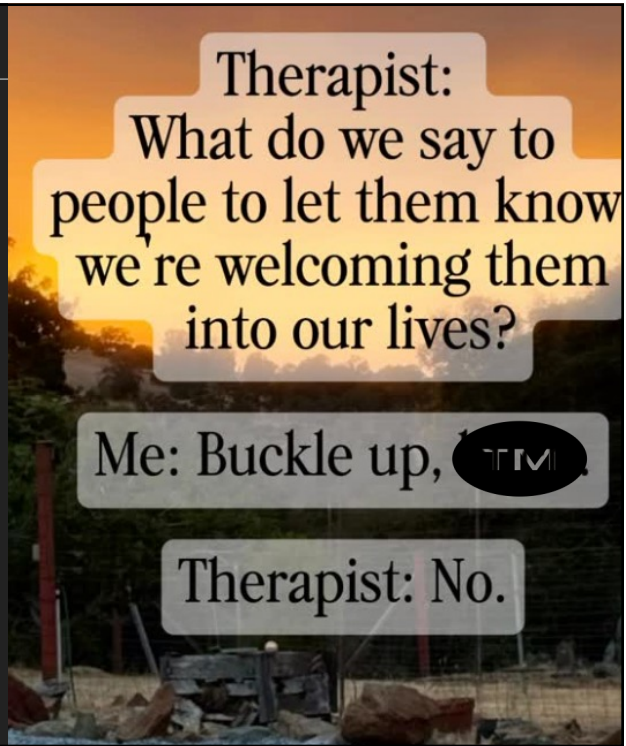
- ▶ Psychiatric disorders generate life stress
- ▶ BPD symptoms generate life stress (Conway et al., 2018)
- ▶ Cross lagged analysis (n=355)
- ▶ Antagonism and Disinhibition predict dependent life stressors not negative affect
 - ▶ Antagonism: struggle to live harmoniously and abide by social norms
 - ▶ Disinhibition: struggle with planning, self-control, and persistence

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GPM-GPS

STRESS REACTIVITY AND STRESS GENERATION

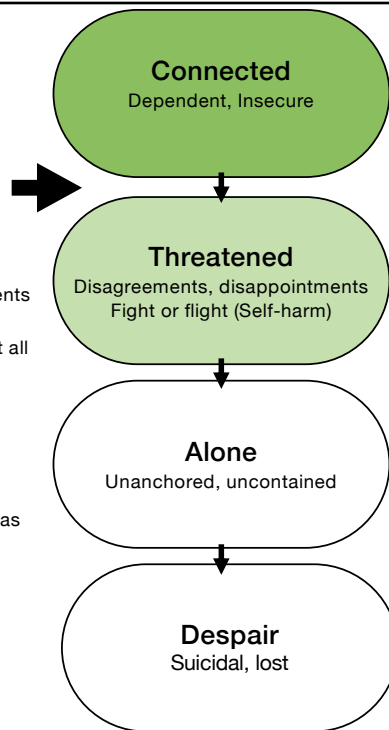
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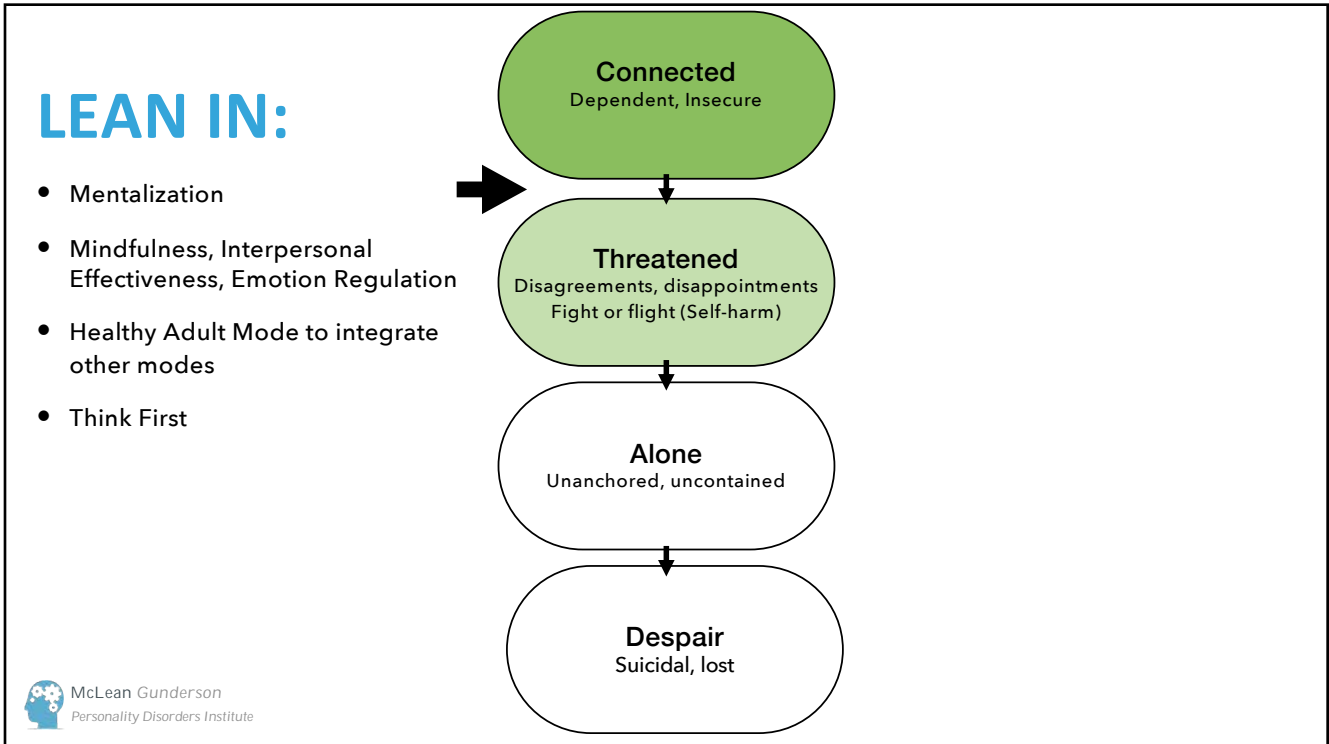
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LEAN IN:

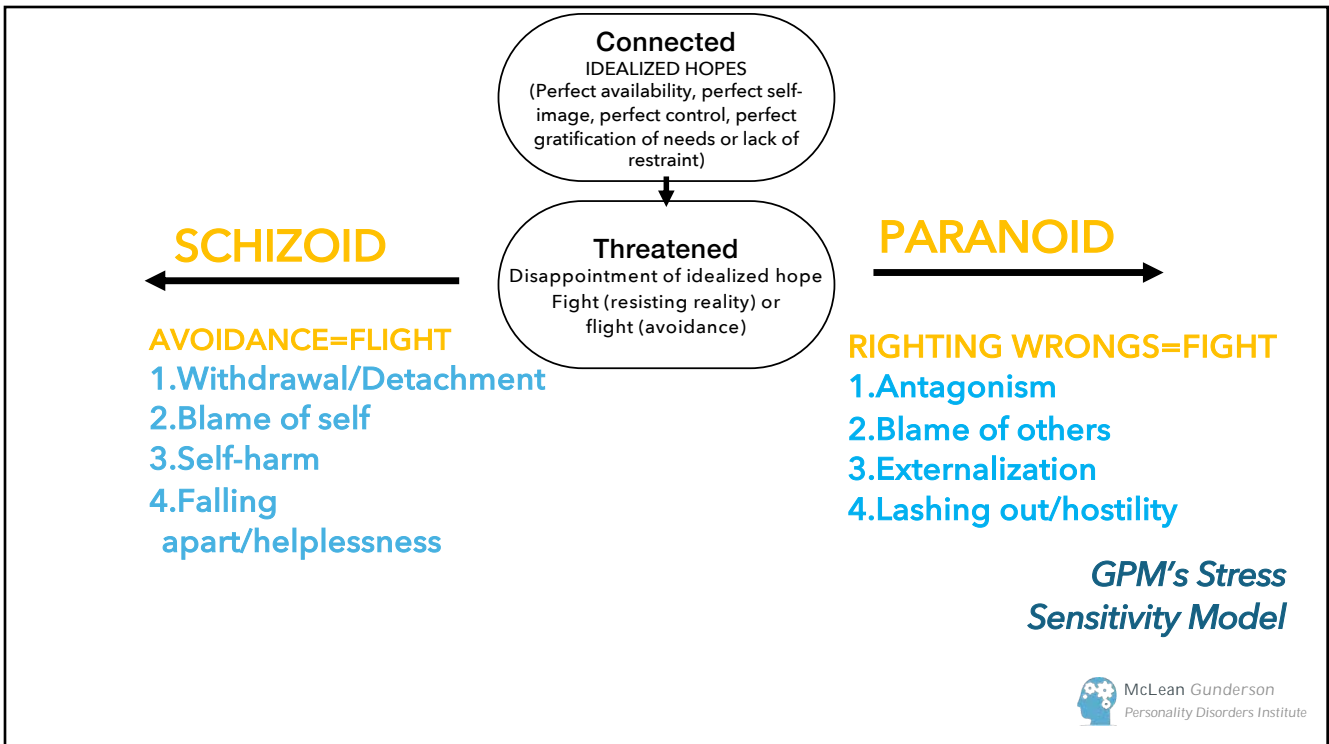
- Appraise and accept reality
- Work out disagreements or misunderstandings, validate disappointments
- Name limitations as a shared problem: not all symptoms have known causes, not all problems have treatments or cures
- Explore ambivalence, motivational interviewing
- Consider good self-care and self-reliance as an antidote to hypersensitivity to others



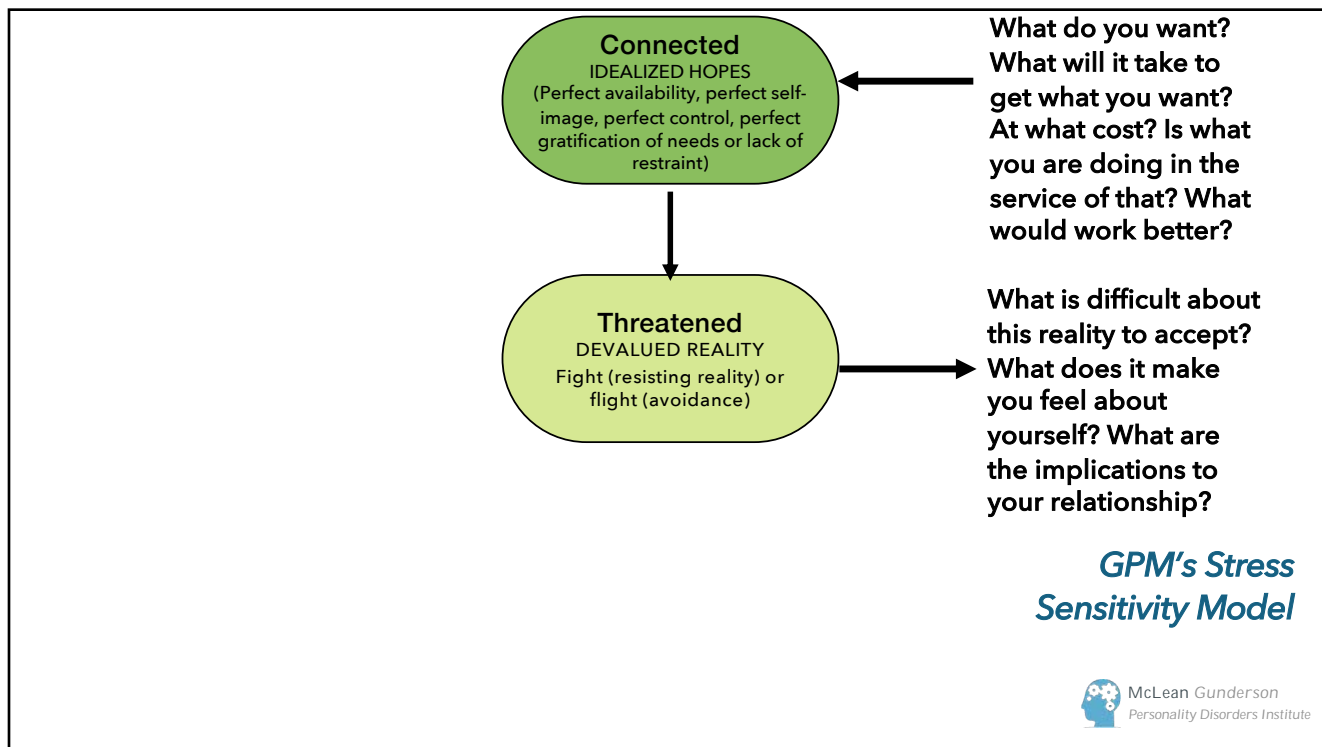
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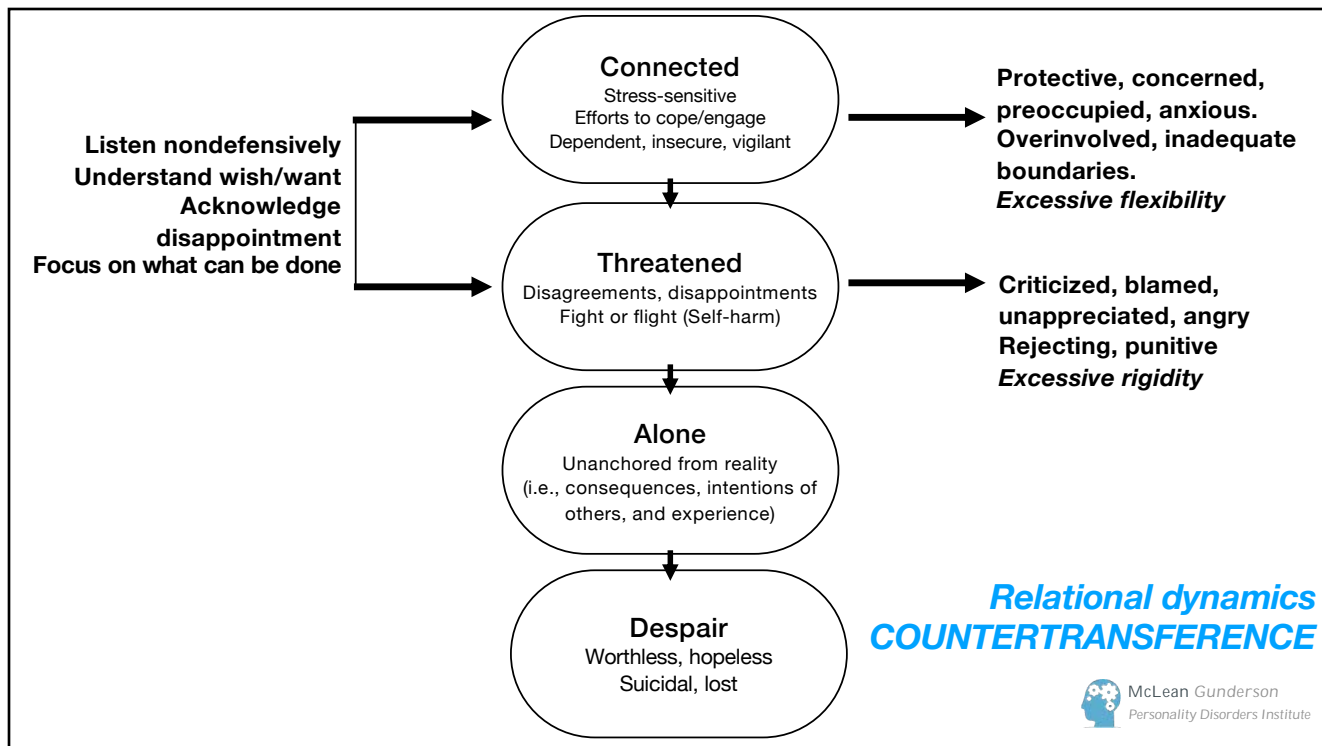
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GPM'S SIX PRINCIPLES

- Be active (responsive & curious) not reactive
- Support via listening, interest, selective validation
- Focus on life outside treatment (time outside visits)
- Professional but real (i.e., honest) relationship (as GP)
- Change is expected (quality of care depends on it)
- Multimodality: broaden the social safety net



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HOW TO'S OF GPM

Be active (responsive & curious) not reactive

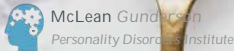
Establish a contract (who does what, when, where, how)

Set and agenda together every visit, stay within time

Support via listening, interest, selective validation

Focus on life outside treatment (previsit and follow up)

What can the patient and a network of resources do



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HOW TO'S OF GPM

Patient-centered care is longitudinal...

Goals are achieved over time
 Priorities change
 New events require new decisions



...but consists of multiple discrete episodes

Patient-provider interactions
 Communication
 Decisions taken and plans made

Pre-Visit
 Phone call,
 On-Line Tools

Visit

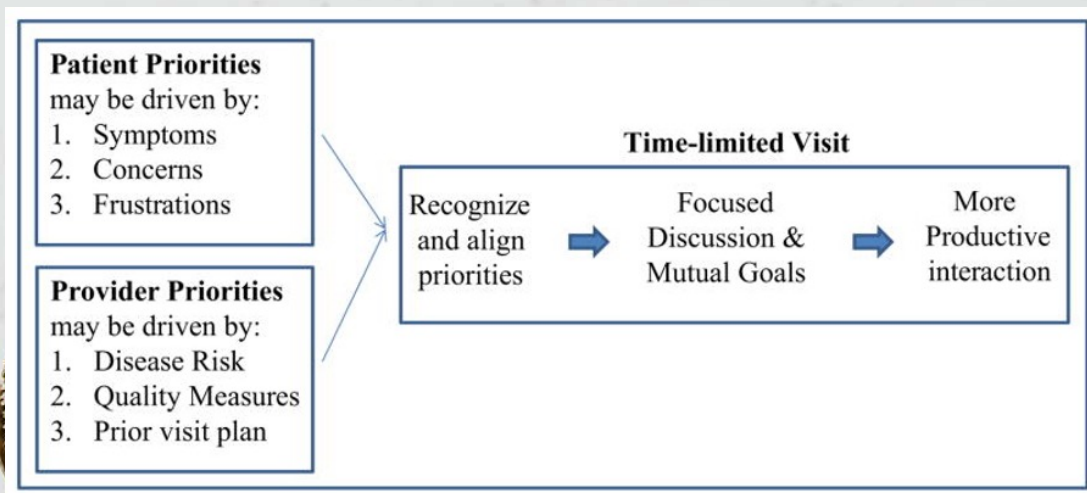
After-Visit
 Follow-up
 Letter or E-mail

The Visit remains the key interaction: Real-time, 2-way communication



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HOW TO'S OF GPM



ACCOUNTABILITY: EXPECTATION TO CHANGE (FACILITATING NATURAL COURSE OF ILLNESS)

TREATMENT IS EVALUATED IN TERMS OF
PROGRESS IN MEETING GOALS

ACCOUNTABILITY: EXPECTATION TO CHANGE (FACILITATING NATURAL COURSE OF ILLNESS)

TREATMENT IS NOT EFFECTIVE IF IT DOES NOT REACH
LONGER TERM GOALS, BUT PROVIDES SOOTHING



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SETTING GOALS FOR ACCOUNTABILITY

LOADING...



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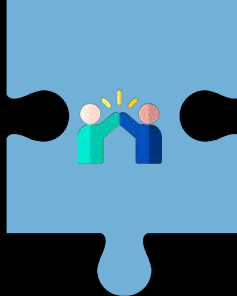
BUILDING AN ALLIANCE SEQUENTIALLY



CONTRACTUAL

(Goals, Roles)

Setting the framework (schedule, fees, confidentiality). Goals and roles structure interpersonal hypersensitivity to promote agency in patient and expectations in treatment



RELATIONAL

(Affective, Empathic)

Liking and understanding the patient. Clinician seen as caring, understanding, genuine, and likable. Should develop by 6 months. If sustained, it is a corrective experience



WORKING


(Cognitive, Motivational)

Patient as a reliable collaborator who can recognize painful observations by the clinician being well intended. This form grows most slowly and is relevant to most therapies

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- **80% of BPD patients engage in suicidal behavior**
 - Average # of attempts: 3
 - 1 completed suicide per 23 attempts
- **Rate of suicide: 3-10%**
 - 50x greater than general population
- **Identity problems, frantic efforts to avoid abandonment, and emptiness predict suicidality**
- **Self-injurious behavior: ↑ suicide risk (2-30x)**

SUICIDALITY

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Linehan et al. (2006); Gunderson (2011); Gunderson & Ridolfi (2001); (Black et al. (2004); Oldham (2006); Leichenring et al. (2011); Bolton and Robinson (2010); Yen et al., (2020)

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GPM-GENERAL PRACTITIONERS

SELF-HARM: BEHAVIORAL HALLMARK

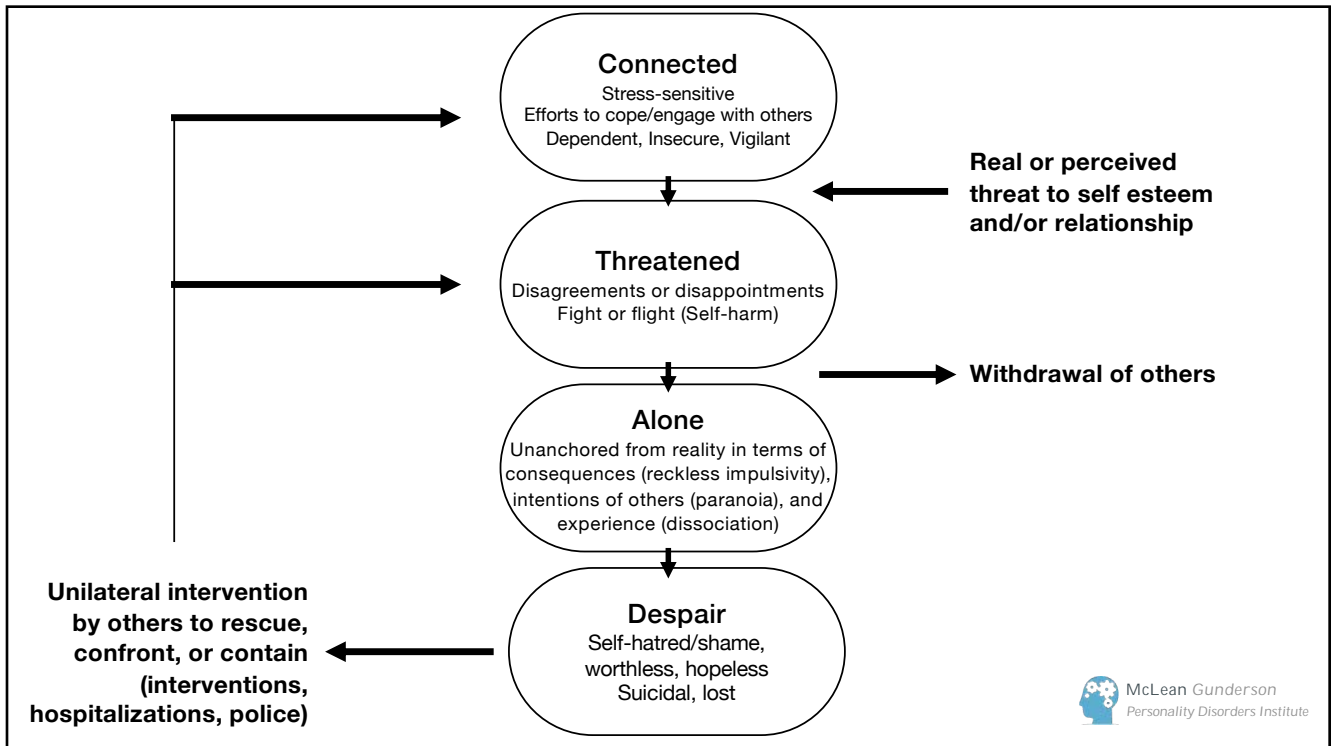
- ▶ **Lifetime prevalence: 16.9% (range across 41 countries 4-39%)**
- ▶ **Mean age of onset: 13 years old**
- ▶ **Approximately half is mild and requires no intervention; 16-27% will be repetitive and more severe**
- ▶ **Multiple functions: Self-regulatory and interpersonal within and between people**
- ▶ **Risk factor of suicide: Lowers barriers**



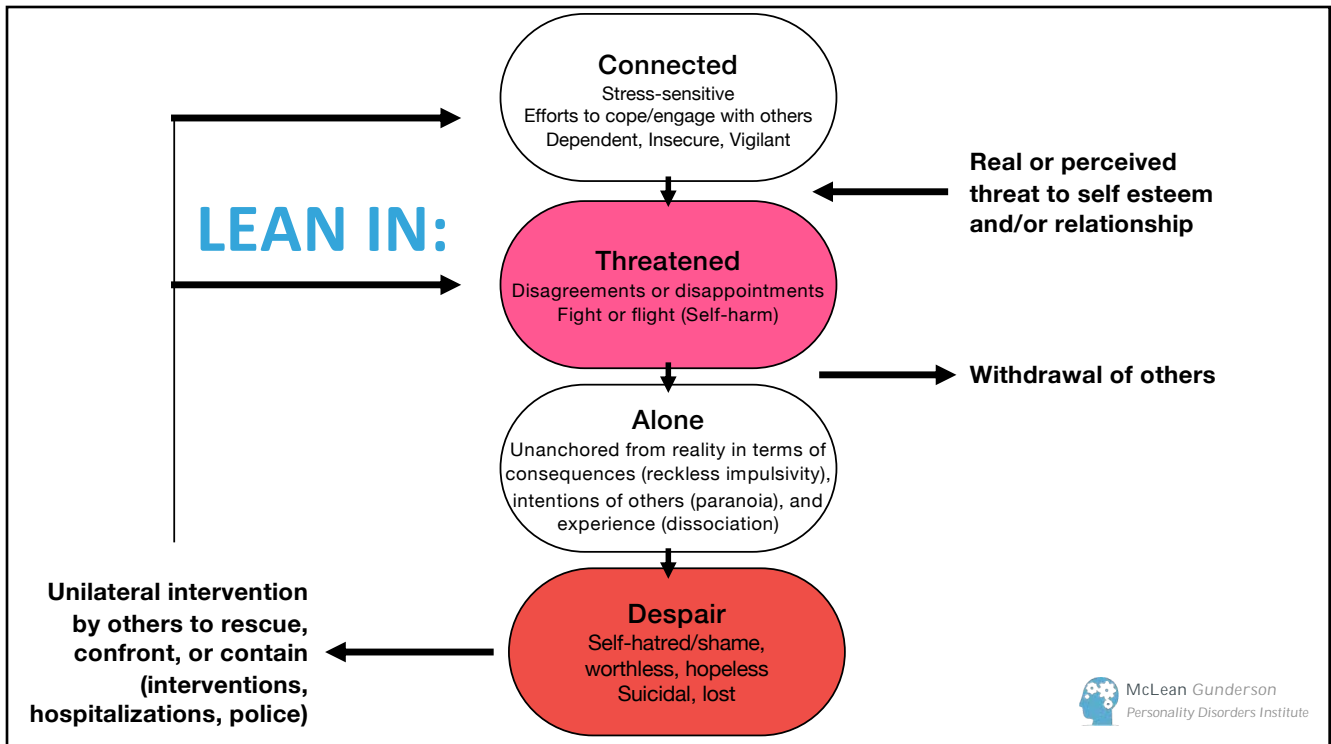
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Coppersmith et al., 2024; Branas et al., 2022

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FACTORS AFFECTING VARIATIONS IN RISK

Increases risk

- ▶ Substance Abuse
- ▶ (-) Interpersonal Events
- ▶ Increased depression
- ▶ Stop down

Decreases risk

- ▶ Low dose antipsychotics
- ▶ (+) Interpersonal Events
- ▶ Crisis skills
- ▶ Hospitalization

ASSESS DANGEROUSNESS

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GPM-GENERAL PRACTITIONERS

MANAGING SAFETY

- ▶ Show concern and assess dangerousness using good psychiatric risk evaluation
- ▶ Put self-harm and suicidality in context of larger life difficulties and interpersonal hypersensitivity
- ▶ Identify problems needing attention (chain analysis)
 - ▶ Increase support system
 - ▶ Develop or revise safety plan
- ▶ Increase level of care if patient cannot collaborate to re-instate processing and collaboration
- ▶ Distinguish containment from ongoing treatment for BPD

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SAFETY PLAN

Step 1: Warning Signs

- Feeling panicky and like I can't breathe; wanting to get out
- Wanting to take pills or drink

Step 2: Coping Using Distraction/Soothing Strategies

- Painting
- Petting my puppy

Step 3: Social Situations/People Who Can Help Distract Me

- My friends Patricia and Marie

Step 4: People I Can Ask for Help
(Note also if a person is unhelpful when you are in crisis.)

- My mom might be helpful
- Do not ask my boyfriend or sister for help during a crisis

Step 5: Professionals or Agencies I Can Contact During a Crisis

- National Suicide Prevention Lifeline: 1-800-273-8255
- List of others to be completed as homework

Step 6: Making the Environment Safer

- Lock my medications up so they are not readily available
- Cut my fake ID in half

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CAUTIOUS AND CONSERVATIVE

PSYCHOPHARMACOLOGY

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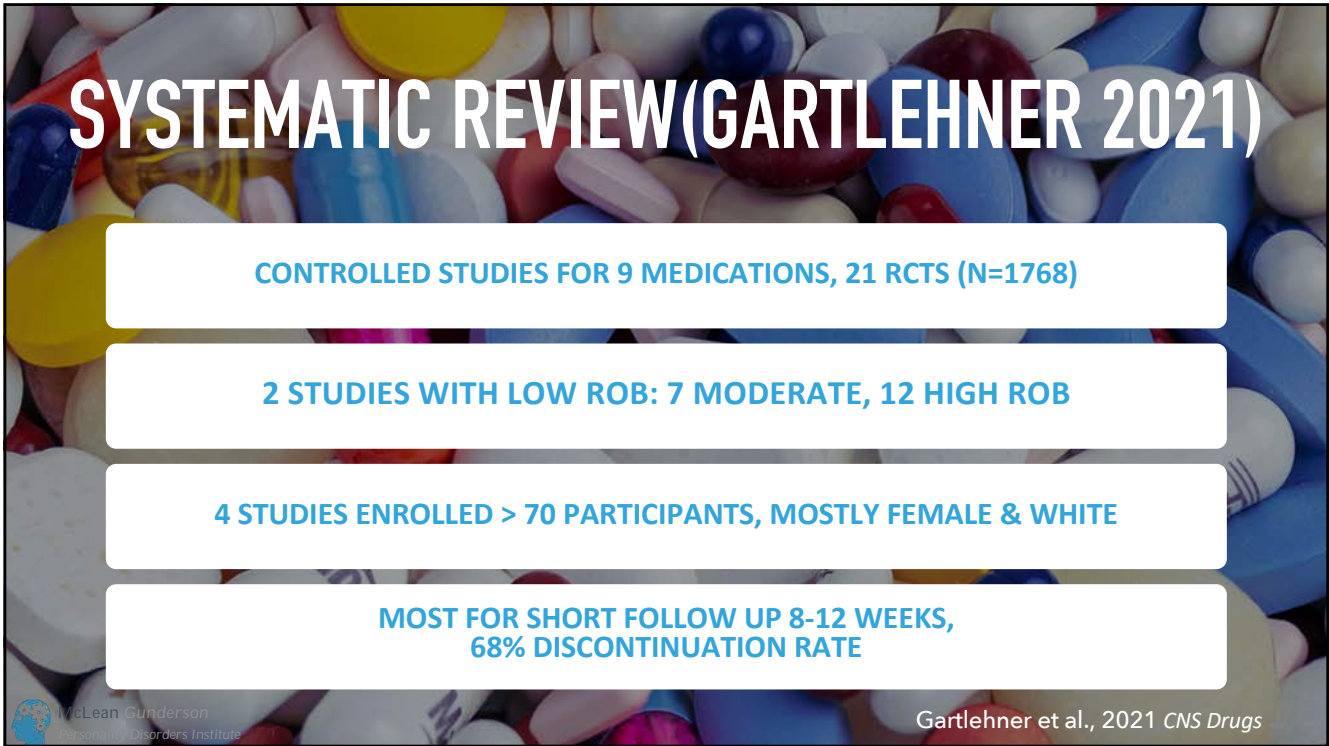
THE STATE OF KNOWLEDGE ABOUT PHARMACOTHERAPY OF BPD

- FEW, INADEQUATELY POWERED, RCTS WITH REPLICATED FINDINGS
- NO DRUG LICENSED BY ANY REGULATORY AGENCY FOR BPD
- OVER 90% ON AT LEAST ONE MEDICATION, APPROXIMATELY ONE IN FIVE PEOPLE ARE ON 4+
- APA GUIDELINES FOR VOTE IN 2024 OMIT DOMAIN TARGETED PRESCRIBING (E.G. AFFECTIVE INSTABILITY, IMPULSIVITY)

McLean Gunderson
Personality Disorders Institute

Gartlehner et al., 2021 *CNS Drugs*

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SYSTEMATIC REVIEW(GARTLEHNER 2021)

- CONTROLLED STUDIES FOR 9 MEDICATIONS, 21 RCTS (N=1768)
- 2 STUDIES WITH LOW ROB: 7 MODERATE, 12 HIGH ROB
- 4 STUDIES ENROLLED > 70 PARTICIPANTS, MOSTLY FEMALE & WHITE
- MOST FOR SHORT FOLLOW UP 8-12 WEEKS, 68% DISCONTINUATION RATE

McLean Gunderson Personality Disorders Institute Gartlehner et al., 2021 *CNS Drugs*

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SUMMARY FINDINGS(GARTLEHNER 2021)

- NO MEDICATION/CLASS REDUCED BPD SYMPTOM SEVERITY
- LOW/VERY LOW CERTAINTY THAT ANTICONVULSANTS IMPROVE ANGER, AGGRESSION, AFFECTIVE LABILITY
- SGA IMPROVE GENERAL SYMPTOM SEVERITY, BUT NOT BPD
- NO MEDICATION IMPROVED FUNCTIONING

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AVOID A DICHOTOMOUS STANCE

“I AM NOT CERTAIN IF MEDICATIONS WILL WORK.
THEY MAY BE HELPFUL.
IT IS IMPORTANT WE MONITOR.”

GUIDELINES FOR SELECTING MEDICATIONS

Assess relevant case factors:

Patient motivation, symptom type and severity, current medications, distress may respond to new medications with placebo effect

Know what medications can and cannot accomplish: Treat co-occurring disorders with tempered expectations regarding BPD

Avoid polypharmacy and benzodiazepines:

Personality features such as passivity, dependency, neuroticism, and avoidance predicts benzodiazepine withdrawal severity

PLACEBO RESPONSE?

- ▶ Placebo yielded significant improvements
- ▶ Affective dysregulation=> moderate effects size
- ▶ Cognitive perceptual and impulsivity=> small effect size
- ▶ Sensitivity of BPD to aspecific therapeutic effects
- ▶ Higher drop out rates than active comparators

Vita, Peri, & Sacchetti, J Clin Psychopharmacology 2011



"Apparently your health insurance only covers placebos."

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The Clinical Effectiveness and Cost-Effectiveness of Lamotrigine in Borderline Personality Disorder: A Randomized Placebo-Controlled Trial

Mike J. Crawford, M.D., Rahul Sanatinia, Ph.D., Barbara Barrett, Ph.D., Gillian Cunningham, B.Sc., Oliver Dale, M.B.B.S., Poushali Ganguli, M.Sc., Geoff Lawrence-Smith, M.B.B.S., Verity Leeson, Ph.D., Fenella Lemonsky, Georgia Lykomitrou, M.Sc., Alan A. Montgomery, Ph.D., Richard Morriss, M.D., Jasna Munjiza, Ph.D., Carol Paton, B.Sc., Iwona Skorodzien, M.Sc., Vineet Singh, M.B.B.S., Wei Tan, M.Sc., Peter Tyrer, M.D., Joseph G. Reilly, D.M., on behalf of the LABILE study team

Objective: The authors examined whether lamotrigine is a clinically effective and cost-effective treatment for people with borderline personality disorder.

Method: This was a multicenter, double-blind, placebo-controlled randomized trial. Between July 2013 and November 2016, the authors recruited 276 people age 18 or over who met diagnostic criteria for borderline personality disorder. Individuals with coexisting bipolar affective disorder or psychosis, those already taking a mood stabilizer, and women at risk of pregnancy were excluded. A web-based randomization service was used to allocate participants randomly in a 1:1 ratio to receive either an inert placebo or up to 400 mg/day of lamotrigine. The primary outcome measure was score on the Zanarini Rating Scale for Borderline Personality Disorder (ZAN-BPD) at 52 weeks. Secondary outcome measures included depressive symptoms, deliberate self-harm, social functioning, health-related

quality of life, resource use and costs, side effects of treatment, and adverse events.

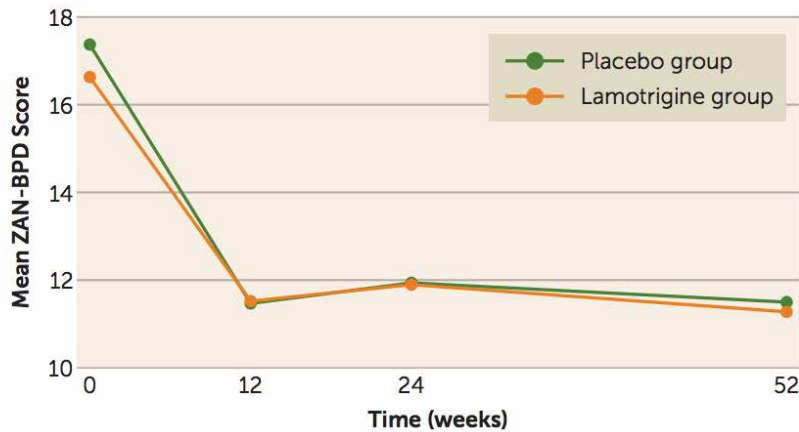
Results: A total of 195 (70.6%) participants were followed up at 52 weeks, at which point 49 (36%) of those in the lamotrigine group and 58 (42%) of those in the placebo group were taking study medication. The mean ZAN-BPD score was 11.3 (SD=6.6) among those in the lamotrigine group and 11.5 (SD=7.7) among those in the placebo group (adjusted difference in means=0.1, 95% CI=-1.8, 2.0). There was no evidence of any differences in secondary outcomes. Costs of direct care were similar in the two groups.

Conclusions: The results suggest that treating people with borderline personality disorder with lamotrigine is not a clinically effective or cost-effective use of resources.

AJP in Advance (doi: 10.1176/appi.ajp.2018.17091006)

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FIGURE 2. Change in Score on the Zanarini Rating Scale for Borderline Personality Disorder at 12, 24, and 52 Weeks in a Placebo-Controlled Study of Lamotrigine for People With Borderline Personality Disorder



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LESSONS FROM THESE FINDINGS

- ▶ No medication has been shown to be a primary adequate treatment agent for BPD
- ▶ Prescription should therefore occur with healthy skepticism of the effectiveness of medications
- ▶ Placebo treatments may be effective for this population in the context of good clinical management
- ▶ Impressive benefits can come from providing regular visits with a focus on symptom monitoring

“Well-delivered, good, plain general psychiatric management can go a long way.”

Medication Management for Patients With Borderline Personality Disorder

John G. Gunderson, MD, and Lee W. Choi-Kain, MD, MEd

For 8 years now, we have been teaching clinicians that lamotrigine is a useful drug for patients with borderline personality disorder based on evidence from two very small studies (1, 2). Lamotrigine seemed to us, and perhaps to many prescribers, to have a pharmacologic profile that could be useful for this patient population. A study reported in this issue by Crawford et al. (3) persuasively documents the disappointing failure of this seemingly promising mood stabilizer to be helpful. This trial of lamotrigine for the treatment of borderline personality disorder reinforces three important lessons about the state of the pharmacologic treatment of the disorder—namely, that no medication has been shown to be an adequate primary treatment agent, that borderline personality disorder is distinct from bipolar disorder, and that placebo may be an effective treatment when delivered in the context of good clinical management.

It is impossible for psychiatrists to avoid treating patients with borderline personality disorder. This group constitutes more than one-fifth of all psychiatric inpatients and emergency (4, 5) and more than one-third of all emergency department visits (6, 7). Usually patients receive this diagnosis only after they have first received multiple trials with psychotropic medications (8). Even after the diagnosis is given, medication treatments are typically continued over many more years (9). This practice has developed despite the fact that no medication has been approved by the U.S. Food and Drug Administration for borderline personality disorder. The U.S. National Institute for Health and Care Excellence has concluded that psychotropic medications should not be used for borderline personality disorder except for the treatment of co-occurring disorders, and then only for the shortest possible time (10).

The use of mood stabilizers for patients with borderline personality disorder has been encouraged by the concept of the disorder as a bipolar spectrum disorder. It is now known that the actual co-occurrence of borderline personality disorder and bipolar I or II disorder is only about 10%, that the progression of bipolar and borderline personality disorders is distinct in itself, and that the two disorders have little effect on each other's course and only rarely evolve into each other (11). The brains of individuals with borderline personality have been shown to be distinctly distinct neurochemically, topographically, and in neural circuitry from those of individuals with bipolar disorder (12, 13). Nonetheless, in

clinical practice, patients with borderline personality disorder are commonly misdiagnosed as having bipolar disorder (14) and frequently receive prescriptions for mood stabilizers, whose use is then continued over time (15). In the absence of benefits from these medications, patients with borderline personality disorder receiving them—or any other ineffective medication—may suffer unnecessary side effects, postpone getting more effective treatments, and, even so, their disease grows, owing to the selective advantage that their brains would, depend on medication effects. The need for caution is underscored by recognizing lamotrigine's potential for severe complications, such as Stevens-Johnson syndrome and toxic epidermal necrolysis (16).

Given the need that psychiatrists should avoid prescribing medications for their patients with borderline personality disorder (16), clinical experience has shown that medications can help build an alliance, can reduce states of distress, and can sometimes be helpful for comorbid disorders. For the 50% of patients with borderline personality disorder who have co-occurring bipolar disorder, psychotropic medication intervention may be necessary for their mood disorder. The Crawford et al. study underlines the fact that medications should be prescribed with healthy skepticism. Both patients with borderline personality disorder and their clinicians can at times idealize the potential effects of medication. Healthy skepticism is an antidote to this sort of idealization on both sides of the therapeutic relationship. The healthy skepticism is indicated in knowing that over 90% of patients with borderline personality disorder remain, with few signs of remission, in the absence of treatments by clinicians trained to treat the disorder (17, 18). Moreover, we now know that nonmedication therapies can be nearly as effective as more intensive therapies delivered by specialists (19).

In the Crawford et al. trial, patients in both the placebo and lamotrigine arms showed clinically significant reductions of borderline symptoms, with a larger effect size observed in one-third of the patients in either arm were achieved, the finding emphasizes both the natural course of remission in borderline personality disorder and the likelihood of a

Gunderson, J. G., & Choi-Kain, L. W. (2018)

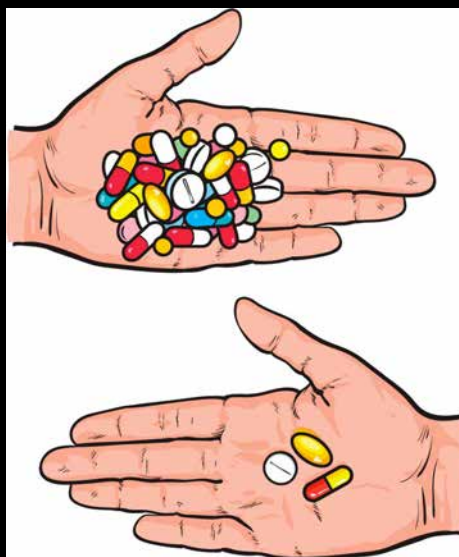
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TIPS ON INVOLVING PATIENTS & DE-PRESCRIBING

Select a time that is not in crisis with a stable alliance. **Collaborate:** "We'll all work together to monitor the side effects & improvements in your symptoms." This will take time.

Validate. "It sounds like dealing with your problems has been really scary for you. It must be hard to feel like you have little control over what happens to you."

Educate and provide psychoeducation. "Here are some pros and cons to taking antidepressants. Here are possible alternatives."



which are about 6 minutes in length were built for that purpose by Lois in collaboration with Rebbe Ratner and production team at BorderlineNotes on YouTube. Lois and Rebbe developed them for a pilot study of a randomized controlled trial of online psychoeducation plus feedback funded by NARSAD, the Brain Behavior Research Foundation, Families for BPD Research, and the Eric Dorris Translational Grant. Findings on this curriculum of 10 short prescription videos to be administered to newly diagnosed people with BPD are in submission for publication but the protocol for the study is published in PLOS One 2023.

★ [CLICK HERE FOR THE PROTOCOL PAPER](#)



1) Symptoms of BPD



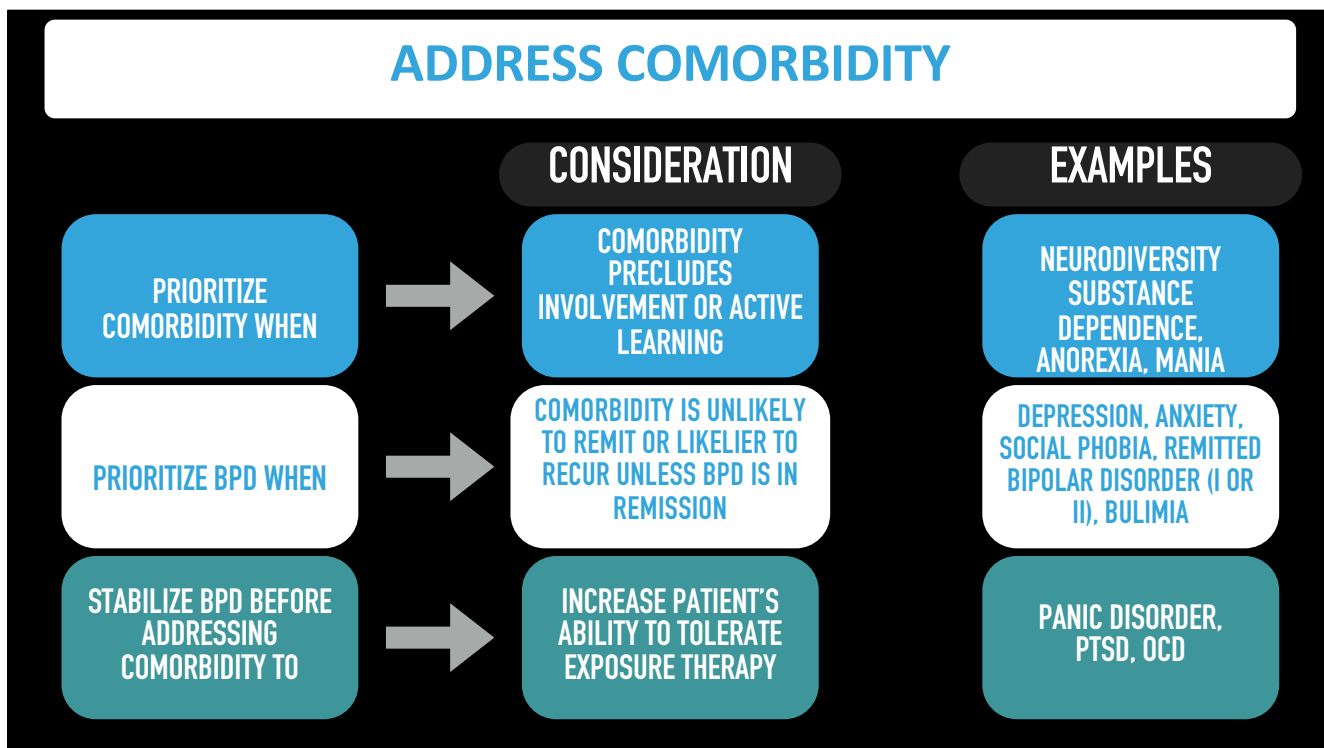
2) Interpersonal Hypersensitivity

WWW.GUNDERSONPDI.MCLEAN.HARVARD.EDU



ACTIVE AND INFORMED MANAGEMENT OF
CO-OCCURRING DISORDERS

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COMORBID ADHD & BPD

LIFETIME COMORBIDITY WITH BPD=>33.69%(NESARC)

COMORBIDITY=> INCREASED IMPULSIVITY, DEPRESSION, ANXIETY, AND PSYCHOSOCIAL DIFFICULTIES

FUNCTIONING AND ANGER/AGGRESSION MAY IMPROVE BY TREATING ADHD

DBT-BASED STRUCTURED SKILLS TRAINING PROGRAM FOR ADULTS W/ ADHD; SKILLS COACHING ON ADHD RELATED THERAPY INTERFERING BEHAVIORS; COMBINATION OF INDIVIDUAL THERAPY AND STIMULANTS/OTHER MEDS

O'MALLEY ET AL 2016; MATTHIES & PHILIPSEN 2014; ASHERSON ET AL 2014

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BPD & DEPRESSION

- ▶ ANTIDEPRESSANTS NOT HELPFUL FOR BPD CORE SYMPTOMS¹
 - ▶ CAN DECREASE DEPRESSION MORE THAN DBT (SEE BRODKSY ET AL. 2025)
 - ▶ SMALL BUT SIGNIFICANT EFFECT ON ANXIETY AND ANGER

- ▶ FOR PATIENTS WITH DEPRESSION, COMORBID PERSONALITY DISORDER DOUBLES RISK OF POOR DEPRESSION OUTCOME (OR=2.20, 95% CI 1.61-3.01)²

1. Ingenhoven, T. J., Lafay, P., Rinne, T., Passchier, J., & Duivenvoorden, H. J. (2010). Effectiveness of pharmacotherapy for severe personality disorders: meta-analyses of randomized controlled trials. Brodsky et al., 2025

2. Newton-Howes, G., Tyrer, P., & Johnson, T. (2006). Personality disorder and the outcome of depression: meta-analysis of published studies. The British Journal of Psychiatry, 188(1), 13-20.

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Dialectical Behavior Therapy Versus Serotonin Reuptake Inhibitor Treatment for Suicidal Behavior in Borderline Personality Disorder: A Randomized Controlled Trial

Beth S. Brodsky, Ph.D.,^{1,2} Hanga Galfalvy, Ph.D.,^{2,3} J. John Mann, M.D.,^{1,2} Michael F. Grunebaum, M.D.,^{1,2} Barbara Stanley, Ph.D.^{1,2}

Objective: The authors compared the efficacy of 6 months of dialectical behavior therapy (DBT) to 6 months of selective serotonin reuptake inhibitors with clinical management (SSRI/M) in reducing suicide-related events (SREs), suicide attempts, nonsuicidal self-injury (NSSI), and related clinical outcomes in individuals diagnosed with borderline personality disorder.

Methods: The study sample comprised 84 individuals with borderline personality disorder; more than one suicide attempt, SRE, or NSSI episode in the past 6 months; and another of these behaviors in the past year. Two-thirds had comorbid major depressive disorder. Participants were randomly assigned to receive DBT or SSRI/M. Poisson models were used to analyze numbers of suicide attempts and SREs, and a zero-inflated Poisson model was used for NSSI behav-

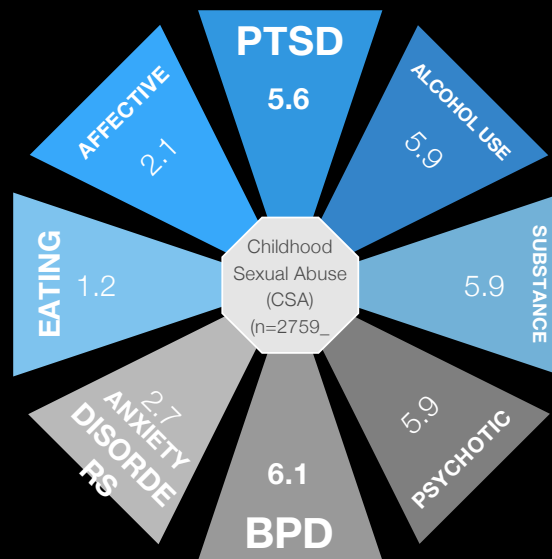
Results: Significantly fewer SREs occurred in the DBT arm compared with the SSRI/M arm during the 6-month treatment phase. Significantly fewer suicide attempts occurred in the DBT arm compared with the SSRI/M arm. Survival analysis indicated significantly lower risk for having any SRE in the DBT arm compared with the SSRI/M arm, but no difference in risk of suicide attempt. DBT participants had significantly lower NSSI counts than SSRI/M participants. Severity of depression and suicidal ideation decreased comparably in both treatment groups. After 6 months of treatment, the rate of major depressive disorder was significantly lower in the SSRI/M arm compared with the DBT arm. At 12-month follow-up (6 months after completion of the treatment phase), outcomes were comparable between the two groups.

Conclusions: Six months of DBT showed greater efficacy

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TRAUMA: A RISK FACTOR FOR A BROAD RANGE OF DISORDERS

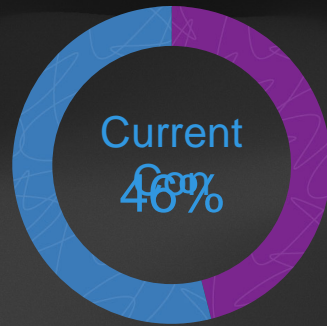
Victorian Institute for Forensic Medicine (1964-1995)
 *2759 sexually abused in childhood
 *4938 Victorian residents



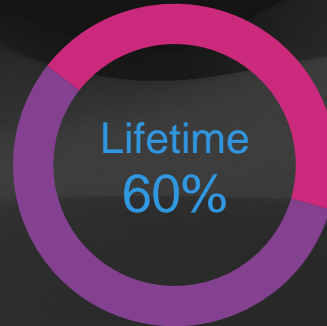
Cutajar et al., 2010

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Most with BPD will have Alcohol Use Disorders



(28-69%; n=761)



(50-63.7%; n=1581)

Alcohol Use Escalates Risk for Suicide

A major modifiable risk factor across psychiatric disorders

1

High Risk for Suicide

HR of 128 for women and 28 for men in predicting death by suicide in 5 years of follow up in large Swedish sample

Acute alcohol use associate with **OR of 6.97** for likelihood of suicide attempt. Even *low level use OR 2.71* and *high level use 37.2*

2

Dose dependent risk

3

Responds to treatment

Naltrexone is a safe and effective treatment that can be combined with behavioral approaches that neither requires abstinence and targets priming responses.



GPM LINKS PUZZLE PIECES OF HEALTHCARE


Combining treatment of BPD with care of other medical and psychiatric conditions



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INGREDIENTS OF GPM



Mechanism

- GOAL 1: THINK FIRST**
- GOAL 2: DEVELOP A CORRECTIVE RELATIONAL EXPERIENCE**
(PEOPLE ARE FLAWED/LIMITED)
- GOAL 3: GET HEALTHY**
(CAN SUSTAIN WELL-BEING MORE DIRECTLY THROUGH LIFE ENHANCING ACTIVITIES)

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**YOU DON'T NEED TO BE
A SPECIALIST OR
SELFLESSLY DEVOTED
TO BE GOOD ENOUGH;
YOU NEED TO BE
WARM, RELIABLE,
INTERESTED, AND
UNINTIMIDATED, AND
YOU NEED TO BASIC
KNOWLEDGE ABOUT
CASE MANAGEMENT**

—
John Gunderson M.D.
Handbook of GPM

McLean Gunderson
Personality Disorders Institute